

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	Roselodge Nursing Home
Centre ID:	OSV-0000088
Centre address:	Killucan, Westmeath.
Telephone number:	044 937 6220
Email address:	orlamc40@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Killucan Nursing Centre Limited
Provider Nominee:	Orla McCormack
Lead inspector:	Jillian Connolly
Support inspector(s):	Liam Strahan
Type of inspection	Unannounced
Number of residents on the date of inspection:	47
Number of vacancies on the date of inspection:	3

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 December 2014 22:00	23 December 2014 04:00
23 December 2014 14:30	23 December 2014 18:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 02: Governance and Management
Outcome 05: Documentation to be kept at a designated centre
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 11: Health and Social Care Needs
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 18: Suitable Staffing

Summary of findings from this inspection

Roselodge Nursing home is located in Killucan, Co. Westmeath and is registered to provide services to fifty residents. This was the seventh inspection of the designated centre by the Authority. The reports can be accessed online at www.hiqa.ie. This inspection was conducted following the Chief Inspector being notified by the provider of five incidents which resulted in residents requiring medical or hospital treatment since the last inspection which was conducted in July 2014. Two of the notifications resulted in residents sustaining fractures. The Chief Inspector issued a provider led investigation following on from this notification which was returned to the Authority on the 2 December 2014. The response was reviewed prior to the inspection and did not assure the Chief Inspector that the services provided were safe and effective and resulted in a positive outcome for residents.

The provider and the person in charge attended the centre following notification from the nurse in charge. Feedback was provided to the provider on day 2 of the inspection.

Inspectors spoke to residents, staff, observed practice and reviewed documentation. Seven Outcomes were inspected, major non - compliance was identified in three of the outcomes and moderate non - compliance was identified in four of the outcomes. Thirteen regulatory failings were identified, nine of which are the statutory responsibility of the provider and four of which are the responsibility of the person in

charge. The overall findings of this inspection were that the governance and management of this centre did not meet the regulatory requirements. There was insufficient staff to ensure the effective delivery of care in accordance with the statement of purpose. These findings are evidenced throughout the report.

The action plan at the end of this report identifies the failings and the actions the provider/person in charge is required to take to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older Persons) Regulations 2013.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Findings on this inspection evidenced that the designated centre was not sufficiently resourced to ensure effective delivery of safe services to residents in accordance with the centre's statement of purpose.

The person in charge is employed on a full time basis and a review of rosters confirmed that their hours of employment were 8.00 hours to 16.00 hours, Monday to Friday. The provider is also present in the centre on a fulltime basis. The deputy person in charge is also employed on a full time basis and is included in the standard compliment of staff involved in the direct care of residents.

Notifications submitted as required by regulation 31 (d) found that there were five incidents resulting in residents requiring medical or hospital attention since the last inspection in July 2014. Two of the notifications reported of residents sustaining fractures. The provider was required to complete a provider lead investigation. The findings of the provider led investigation were submitted to the Authority on the 2 December 2014. Contained within the provider led investigation report, five findings/outcomes were identified by the provider relating to staff not adhering to policy, inadequate communication and inadequate documentation pertaining to assessment. The Chief Inspector had also requested for the provider to provide evidence that they had ensured that the number and skill mix of staff were appropriate having regard to the needs of the residents and the size and layout of the designated centre. The provider did not provide the adequate assurances in their response.

On inspection, Inspectors confirmed the provider's findings that the policies of the organisation were not consistently adhered to particularly in relation to medication practices and falls management. Inconsistencies in assessment of need and

documentation resulted in negative outcomes for residents. Inadequate communication resulted in a risk of residents' health care needs not being consistently met as staff were not sufficiently informed of a change in need to residents. Whilst inspectors recognised that improvements had been made in the systems introduced by the person in charge since they commenced their post in January 2014, the systems were not robust and were not being consistently implemented. This was identified as a finding in numerous reviews of accidents and incidents by the person in charge; however inspectors determined that the breakdown in communication, inadequate documentation and implementation of policy continued to contribute to services not being safe and consistent. This is further discussed in outcome 8, 9, 11 and 18.

As described in Outcome 17, inspectors also found that there were inadequate staffing resources from 20.00 hours to 24.00 hours to ensure that the needs of residents were being met. Inspectors also found that staffing levels were standardised and not assessed or reviewed following a change in circumstance, such as a change in the needs of residents or an outbreak of Norovirus as outlined in Outcome 7.

Judgment:

Non Compliant - Major

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors identified practice on this inspection which demonstrated that the policies and procedures of the organisation were not being consistently implemented. As stated in Outcome 2 and 7, the falls management policy was consistently breached and evidence as presented in Outcome 12, demonstrated that the medication management policy was also not adhered to. The designated centre had a policy regarding the admission and discharge of residents; however inspectors determined that it required review. The policy did not state the process in place for residents who were admitted for respite services. Documentation reviewed by inspectors evidenced that this was required due to the negative outcome for one resident based on the assessment and care planning process.

Deficits were also identified regarding the records to be held in respect of residents as required by Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older Persons) Regulations 2013. There was no plan of care for residents who had a diagnosis of dementia as this was not identified in the initial assessment. Records in relation to the administration of medication were also inaccurate as stated in Outcome 12.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The designated centre has a risk management policy in place however due to the failings identified on this inspection, it was found that it was not effectively implemented. Inspectors reviewed the risk register and observed that whilst there were some risks assessed which were relevant to the designated centre such as the storage of wheelchairs in the sitting room and algae on the footpath, dates of assessment were omitted therefore reducing the ability to evaluate the time frames in which the effectiveness of the control measures should be evaluated. Inspectors observed that there were risks specific to individual residents which had not been adequately assessed, such as the re- assessment of the risk of falls following on from a fall occurring therefore reducing the effectiveness of learning from the events and reduction of a re occurrence.

As discussed in Outcome 11, there were deficits identified in the inconsistencies of the documentation of falls. The designated centre had a system in place in which residents were assessed monthly for a risk of falls. Inspectors reviewed documentation of residents who had recurrent episodes of falls and found risk assessments had not been consistently completed following on from each incident to assess if the risk to the resident had increased outside of the monthly assessment. Therefore existing control measures had not been reviewed in a timely manner to assess the effectiveness of same and residents fell more than once within the month. This was also in contravention to the organisation's own falls policy which had been reviewed in May 2014 which stated that after assessment and treatment of a resident following a fall, staff should assess the cause of the fall and potential ongoing risk.

There was also an absence of the assessment of the risk due to the levels of staff reduction throughout the day. As stated in Outcome 17, the highest compliment of 2

staff nurses and 8 care staff were between 08.00 hours and 14.00 hours. Nursing staff were reduced by 50 % from 14.00 hours to 08.00 hours the following day. Care staff were reduced by 50 % between 14.00 hours and 16.00 hours. Care staff were reduced by 75% between 22.00 hours and 08.00 hours. There was no assessment of risk completed to ascertain if the reduction in staffing at these times were safe and effective.

The Chief Inspector was notified by the registered provider regarding the suspected outbreak of Norovirus on the 9.12.2014 in accordance with requirements under regulation 31, which affected nine residents and two staff members. Norovirus was subsequently confirmed. Prior to inspection, inspectors reviewed the information provided to ascertain if the management of the outbreak was in line with the prevention and control of healthcare associated infections standards published by the Authority. Whilst the information submitted to the Authority evidenced adherence to the standards and the organisational policy, inspectors identified deficits in the procedure. The provider had informed all of the relevant external parties including the regional infection control nurse, the local general practitioner and the department of public health in line with best practice. Staff on inspection informed inspectors that individual staff were assigned responsibility to care only for residents affected and were able to inform inspectors of the appropriate measures such as the use of personal protective equipment and appropriate hand hygiene. However inspectors found that no additional staff had not been allocated during the outbreak particularly at night. Therefore one care staff had been assigned to care for nine residents whilst the second care staff on duty from 22.00 hours to 08.00 hours had the responsibility of the remaining forty one residents. There had been no assessment to confirm if this system reduced the risk to other residents. Eight residents were initially affected and an additional resident was affected three days following the initial outbreak. Standard 10 of the National Standards for the Prevention and Control of Healthcare Associated Infections recommends redeployment of staff to manage any outbreaks. The person in charge completed re-education with staff on appropriate hand hygiene practices following on from the outbreak and further training in infection control has been scheduled for February 2015.

The centre had a system in place in which the individual needs of residents in the event of an evacuation were reviewed on a weekly basis. The procedure in place clearly stated that it was to be updated more regularly if a change in need was identified. There had been two residents admitted since the last review both who required assistance with their mobility needs. However inspectors observed that their evacuation needs had not been included and staff on duty on the night of inspection were unaware of the assistance the newly admitted residents may require in the event of an emergency, reducing the effectiveness of the procedure in place and presenting a risk to residents and staff.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors inspected the storage of medication and were assured that it was stored within a secure location. Inspectors reviewed a sample of administration and prescription sheets for residents and identified that the prescription sheet contained all of the necessary information such as the name of the medication, a photograph of the resident and the date of birth of the resident. Inspectors found that medication was not prescribed at specific times by the prescriber and the times for medication to be administered were approximate times of the day such as Lunch or Tea. However the administration records pre-stated a specific time of administration such as 08.30 hours or 22.00 hours.

At commencement of inspection the nurse on duty was administering medication. Inspectors were verbally informed that medication commences being administered at approximately 20.30 hours each evening after nursing staff had completed the relevant communication from the day to night staff. On the evening of inspection, medication administration concluded at 22.40 hours. Inspectors were informed that this was unusual and generally medication administration concludes at 22.00 hours. As the times of administration were pre printed on the administration records, the administering staff were signing that they had administered medication at 22.00 hours when it was actually administered at 20.30 hours, which is not in line with the guidance provided to nurses on medication management by An Bord Altranais. There was also no clear system in place to ensure that residents receive medication at the same time consistently each evening. Inspectors also observed risk in relation to staff recording the administration of medication in the twelve hour clock as opposed to the twenty four hour clock, for example medication was recorded as being administered by the same staff at 01.00 and 11.45 hours. However inspectors were verbally informed that this could not have occurred as staff nurses work either day shift which is between 08.00 and 20.00 hours or night shift which is between 20.00 hours and 08.00 hours. Therefore as stated in Outcome 5, the records as required by Schedule 3 were inaccurate. The administration sheet had sufficient space for staff administering medication to record if medication was withheld or refused. Inspectors observed that if medication was administered outside of the standard pre – stated medication administration times i.e. 20.30 hours – 22.00 hours, this was recorded.

The designated centre has a policy of nursing staff having protected time when administering medication by utilising a 'red apron' as a symbol. However inspectors observed that nursing staff were not wearing the red apron whilst administering medication. Inspectors observed that the one nurse on duty was interrupted frequently as care staff required the support of the nurse and there were also interruptions to respond to open the front door for visitors.

As described in Outcome 11, there had been two new resident admissions and one resident re-admitted from an acute setting to the designated centre since staff working

on the night of inspection had last been on duty. Inspectors observed through administration records and through speaking to staff that residents who were prescribed pain relief as required had received the medication at 12.20 however upon speaking to staff, at the time of administration they had not had the opportunity to review the assessment and subsequent care plans for the resident, therefore they were not aware if a pain assessment had been completed for the resident, the reason why the resident was stating that they were in pain or the rationale for why the resident was admitted. There was also a resident who was prescribed oxygen continuously however staff were not able to inform inspectors of the correct flow of oxygen per minute prescribed or what the acceptable saturation of oxygen level should be, as they did not have the opportunity to review the residents' records until 02.30 hours, which was six and half hours after their shift had commenced.

Inspectors reviewed the medication audits available; the last recorded audit which had been conducted in conjunction with the pharmacist had been completed in March 2014. There was also a record maintained of medication errors, with one medication error recorded since the last inspection which was as a result of a resident being administered medication prescribed for another resident due to mis identification of the resident. Inspectors reviewed the outcome and action taken by the person in charge and was assured that the necessary steps had been taken to prevent a re-occurrence. She confirmed that there had been no adverse effect to the resident.

Judgment:

Non Compliant - Major

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors reviewed a sample of residents' personal files and found that due to inconsistency in assessment of need, documentation and inadequate communication between staff, there was a risk present to the health care needs of residents being met. Inspectors reviewed the personal files of residents who had been involved in accidents/or incidents. There were inconsistencies in the documentation regarding residents falls, therefore the actual risk to residents was not clear. For example, falls of individual residents were not recorded in the same location. The designated centre has a falls management policy in place which stated that each fall of a resident should be

recorded in individual falls' diary. However in some instances falls were recorded in the care plan of the resident and in other instances in the falls' diary therefore decreasing the accuracy of the information in the falls' diary and not reflecting the actual risk for the resident. Staff informed inspectors that they were not aware of any resident falling since they had last been on duty. Inspectors reviewed the accident/incident log and observed that there had been three falls to residents since staff had last been on duty. Inspectors also observed residents at risk based on the inaccuracy of information obtained in the initial assessments of residents. Residents who had a history of falls had been recorded of having no history of falls in their initial assessment. There was evidence that residents who recurrently rolled out of bed had been assessed as not being suitable for utilising bedrails however there had been no assessment for alternative interventions such as low low beds or crash mats. Inspectors recognised that there had been improvements in the structure of the care plans for residents since the previous inspection. Of the sample of care plans reviewed, inspectors determined that the interventions to meet the need were in the main specific and informative however there was an absence of care plans for specific needs such as dementia and confusion.

Inspectors reviewed the progress notes of a resident which stated that the resident required two hourly re-positioning. Staff on duty on the night of the inspection were not aware of this need until 02.20 hours. Therefore the resident had not been repositioned every two hours from 20.00 hours as required.

As stated in Outcome 12, inspectors observed risk in relation to the staff knowledge regarding the medication that was prescribed for residents and the rationale for same. Therefore inspectors were not assured that residents were receiving appropriate medical and health care as required by Regulation 6 (1).

Judgment:

Non Compliant - Major

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Inspectors observed throughout the inspection that numerous bedroom doors remained open during the night. The provider stated that this was a result of a choice of the resident. However staff on duty stated that it was to make it easier to check on

residents. One incident report form reviewed by inspectors stated that the resident fell at 07.30 hours as a result of getting out of bed to close the door.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Based on the cumulative findings of this inspection, inspectors were not satisfied that the number and skill mix of staff were appropriate having regard to the assessed needs of residents and the size and layout of the designated centre. Inspectors reviewed a sample of rosters and confirmed that the standard staffing levels for staff involved in direct care provision to residents were as follows:

- 08.00 – 14.00: 2 staff nurses and 8 care staff
- 14.00 – 16.00: 1 staff nurse and 4 care staff
- 16.00 – 20.00: 1 staff nurse and 5 care staff
- 20.00 – 22.00: 1 staff nurse and 3 care staff
- 22.00 – 08.00: 1 staff nurse and 2 care staff

Inspectors were informed as stated in Outcome 12, that the administration of medication at night generally takes 1 hour and 30 minutes to complete, commencing at 20.30 hours and concluding at 22.00 hours. Despite the policy stating that staff administering medication should have protected time to decrease the risk of errors, inspectors observed the staff nurse being interrupted regularly to attend to other tasks as they were the only staff nurse on duty. Another risk present as a result of this was that the staff nurse who is the senior member of staff on duty at night, does not have the opportunity to review residents' records until approximately 02.30 hours in the morning. The negative outcomes for this system were evident on the night of inspection, through staff not being aware of the clinical needs of residents or the needs of residents in the event of an emergency until they had been on duty for a minimum of six hours. On the night of inspection, of the forty seven residents residing in the centre, 15 had a maximum dependency level, 13 had a high dependency level, seven had a

medium dependency level, eleven were assessed as having a low dependency level and one resident was assessed as independent. Twenty seven of the residents were assessed as having a cognitive impairment. As stated previously there had been no assessment completed by the provider to assess if the staffing levels were adequate to meet these needs.

There was a deficit in the communication between staff completing the day shift and staff commencing the night shift, as information to ensure that the health care needs of residents were being met in the short term and changes to the status of residents such as an increase risk of falls were not effectively communicated.

Inspectors found that there was non-compliance with regulation 16 (1)(b) as staff were not appropriately supervised. The person in charge and the provider informed inspectors that they engaged regularly with staff through staff meetings and formal education such as the hand hygiene training mentioned in Outcome 7. However of the accidents and incidents reviewed, the recommendations consistently stated that the policies and procedures of the designated centre were to be adhered to. There was no evidence of further follow up with particular members of staff to ascertain their understanding or an assessment of competency in relation to the implementation of policies and procedures, with the exception of the medication error.

Judgment:

Non Compliant - Major

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Jillian Connolly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Roselodge Nursing Home
Centre ID:	OSV-0000088
Date of inspection:	22/12/2014
Date of response:	04/02/2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Findings on this inspection evidenced that the designated centre was not sufficiently resourced to ensure effective delivery of safe services to residents.

Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

purpose.

Please state the actions you have taken or are planning to take:

We have evaluated the management of future outbreaks and risk assessments will be carried out and dynamic staffing levels will be implemented.

Proposed Timescale: 28/02/2015

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Notwithstanding that reviews were completed following each incident or accident. The re occurrence of incidents did not evidence that the actions taken following the reviews reduced the risks to residents.

Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

The appropriate policies and procedures are in place. Staff are requested to sign off that they have read and fully understand the policies, Copies of the polices have now been allocated to staff and random discussions of the policies are taking place to continue to develop staff knowledge and skills. Staff retraining and re-education is ongoing. Disciplinary action will be taken if there are further breaches in policies and procedures. All issues have been addressed during appraisals and will continue through staff meetings. Roles and responsibilities have been clearly redefined to all staff members. Communication between staff on duty and management will increase during off peak hours.

Proposed Timescale: 31/01/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Whilst the policies and procedures as required by Schedule 5 were in place, they were not consistently implemented in practice. A review was required of the admissions and discharge policy.

Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:

There is a comprehensive admissions policy in place but due to inconsistent information received from the acute setting on the residents needs we have now implemented a pre respite admission assessment. Prior to accepting the resident and to ensure that the needs of the resident can be met this assessment will be completed by the DON or staff nurse on duty. We have reviewed our admissions policy and in order to facilitate a timely and appropriate admission of the resident into our facility, we no longer facilitate admissions after 3pm which is reflected in our updated admissions policy.

Proposed Timescale: 31/01/2015**Outcome 08: Health and Safety and Risk Management****Theme:**

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Hazards and assessment of risks such as reduction of staffing levels at various points during the day had not been assessed.

Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:

Risk assessments have been carried out and will continue to be carried out throughout the centre. These will in turn be audited and control measures will be put in place in an appropriate timescale.

Proposed Timescale: 31/03/2015**Theme:**

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The learning and actions taken from serious incidents was not evident as incidents were re-current.

Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:

Whilst there is a comprehensive risk management policy in place and all incidents are fully investigated , all future serious incidents or adverse events investigations will be documented and evaluated under the following heading : (a) Proposed actions , (b) Persons responsible for actions, (c) Timeframe ie. date for review and date for actions if any, are to be completed, (d) resource requirements. The learning outcomes of these investigations will be made available to all staff members.

Proposed Timescale: 31/03/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Staff on duty on the night of inspection were not clear of the evacuation needs of all residents.

Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:

We have a clear and concise policy in place which was not adhered to by staff on duty. All staff members have been requested to re-read, understand and adhere to all policies and procedures in the centre and random discussions of the policies will take place to continually develop staff knowledge. Management will continue to implement, supervise and monitor all aspects of fire safety .

Proposed Timescale: 28/02/2015

Outcome 09: Medication Management

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Medication was administered to residents without staff having a clear understanding for the rational of same.

Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:

Whilst all staff have completed medication management training in 2014 , all nursing staff will be supported with further in house training which will be facilitated in conjunction with management and our pharmacist. The importance of strict adherence to the medication management policy and actual practice in administration has been exemplified to all staff nurses.

Proposed Timescale: 28/02/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Information recorded in a sample of residents' assessments reviewed by inspectors was not accurate.

Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:

There is a comprehensive admissions policy in place which has been reviewed and amended to include a pre respite admission assessment. The policy is there to support staff in conjunction with management in the correct procedures and assessments that must be carried out immediately before or on admission to the centre to ensure a comprehensive and personalised assessment of each residents identified health and social care needs. The importance of adherence to the assessment, care planning process and clinical care has been identified to all nursing staff.

Proposed Timescale: 31/01/2015

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was an absence of care plans in place for identified needs of residents.

Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:

To eliminate inconsistencies of information, when a resident is transferred from the

acute setting we have re-evaluated our admissions policy in order to clearly indentify the needs of the resident and therefore ensure that the appropriate care plans are in place in less than 48 hours of admission. Person-centred care is our guiding principle and the "unique value of the person" should be recognised in every individual care plan. Care needs are provided in such a way that the person with or without dementia is valued, respected, treated with dignity and supported to live well and enjoy a good quality of life.

Proposed Timescale: 28/02/2015

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The healthcare needs of residents were not being met in line with evidence based practice.

Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:

We will implement a system to ensure that all relevant information is provided, received and communicated to relevant staff to ensure that the appropriate healthcare and medical needs of the residents are met. Staff have been re-educated on the appropriate use of the communication book which will be referenced and communicated throughout the shift.

Proposed Timescale: 01/01/2015

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Bedroom doors were open whilst residents were sleeping. It was not clear the rationale for this practice and inspectors determined that in some instances it compromised the dignity of residents.

Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:

Residents choices have been sought and documented in their care plans regarding their wishes and communicated to all staff and the responsibility lies with the staff on duty to ensure that the residents' wishes are met which will be monitored by management by carrying out inspections.

Proposed Timescale: 28/02/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The registered provider did not ensure that the staffing levels and skill mix of staff were appropriate to meet the assessed needs of the current residents.

Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:

We have been reviewing staffing levels at various times of the day to ensure that our service is maintained to a high standard. We are implementing an additional staff member to the twilight shift. We have devised a specific role for this staff member. We are confident that this will address previous distractions that may have occurred to the staff nurse whilst administering medications. This will be reviewed on an ongoing basis to ensure that it is impacting on the quality service enjoyed by residents

Proposed Timescale: 31/03/2015

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff were not appropriately supervised.

Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:

Following on from our inspection the DON met individually with all nursing staff to clearly redefine their roles and responsibilities and during off peak hours staff will be supported in their roles and responsibilities.

Proposed Timescale: 31/01/2015

