<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mullinahinch House Private Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000148</td>
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<tr>
<td>Centre address:</td>
<td>Mullinahinch, Co. Monaghan, Monaghan.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>047 72 138</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:mullinahinch@yahoo.ie">mullinahinch@yahoo.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Mullinahinch House Private Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Aidan Murray</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Louisa Power</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>55</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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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.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 December 2014 10:30</td>
<td>17 December 2014 18:00</td>
</tr>
<tr>
<td>18 December 2014 09:30</td>
<td>18 December 2014 17:30</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
<th>Outcome 02: Governance and Management</th>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
<th>Outcome 07: Safeguarding and Safety</th>
<th>Outcome 08: Health and Safety and Risk Management</th>
<th>Outcome 09: Medication Management</th>
<th>Outcome 11: Health and Social Care Needs</th>
<th>Outcome 15: Food and Nutrition</th>
<th>Outcome 18: Suitable Staffing</th>
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**Summary of findings from this inspection**

This monitoring inspection was unannounced and took place over two days. This inspection was the fifth inspection of the centre by the Authority. As part of the inspection, inspectors met with residents and staff members, observed practices and reviewed documentation such as care plans, medical records, policies and procedures, medication records and risk management documentation including fire safety and accident and incident records.

Due to the number of non-compliances found on the registration inspection of 13, 14 and 20 February 2013 and lack of detail contained in the provider’s action plan response to the registration inspection, a meeting was held with the provider, person in charge and senior nursing team in the Authority’s Dublin office on 25 June 2013. A follow-up inspection was completed to assess progress with completing the action plans from the registration inspection in July 2013 and improvements were noted in the four areas reviewed. However, the findings of this inspection evidenced that required actions from the last inspection in July 2013 were not completed, while timeframes proposed by the provider in his provider response to the action plans had expired. These areas of ongoing non-compliance with the Legislation are:

- Staff training in fire safety and fire drills
- Resident restraint management and care planning
- Adequate staffing levels/skill mix and staff supervision.

On this monitoring inspection, inspectors also found major non-compliance with the legislation in relation to clinical governance and management processes, inadequate provision of appropriate medical and healthcare, including a high standard of nursing care for residents with deteriorating health and failure to adequately implement the procedures consistent with the Standards for the Prevention and Control of Healthcare Associated infections including antibiotic stewardship. An immediate action plan was issued to the provider and person in charge in respect of these two areas to ensure the needs of residents were adequately met. The provider response received, as requested referenced the actions taken to address infection prevention and control procedure non compliances but lacked adequate detail in relation to ensuring the medical and healthcare needs of residents were met. The action plans are restated at the end of this report for the attention of the provider and person in charge.

Staffing supervision and staffing levels/skill mix did not adequately meet the needs of residents and there was evidence of major negative outcomes for residents especially at night. A high dependency room was not adequately staffed to meet the needs of resident requiring 24 hour high support nursing care as defined by the National Standards.

Other findings constituting moderate non compliance with the legislation included incomplete resident documentation and policies and procedures to inform evidenced based practice in the centre which posed a potential risk to residents of unsafe or/and inappropriate care. Restraint management was not of an adequate standard. A review of the governance procedures in the centre by inspectors did not provide evidence of adequate systems in place for monitoring the quality and safety of care including risk management procedures.

The Action plan at the end of this report identifies mandatory improvements that must be made to meet the requirements of 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.

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 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A statement of purpose document was available and the provider confirmed the copy forwarded to the Authority as part of the centre’s registration documentation in July 2013 was the most up to date copy available. This copy was reviewed by inspectors. The following information requires review.

- The document was dated to cover the period 14 July 2010 to 13 July 2013 and was overdue for review.
- Staffing numbers were not accurate.

Judgment:
Non Compliant - Minor

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):
No actions were required from the previous inspection.

Findings:
While there is a management structure in the centre with the provider, person in charge and two staff nurses who deputise for the person in charge, the roles and responsibilities of other persons who were involved in the management of the centre were not explicitly defined to ensure that lines of authority and accountability were clearly established. The provider and person in charge worked full-time in the centre.

The inspectors found that while documented monitoring of quality and safety was carried out on some aspects of care, this activity was limited in that monitoring systems in place were ineffective as they did not identify the areas of risk and inadequate practices which were identified by inspectors during the days of inspection. For example, the results of medication management audits were made available to the inspectors by the person in charge. The audits covered a limited number of aspects in relation to medication management, including the administration of injections as per schedule and as such the validity of the medication management audits were not satisfactory in that they did not identify deficits in antibiotic prescribing, policy documentation to inform
practice or incomplete medication prescriptions. Audits of resident accidents and incidents were also reviewed and did not identify specific times where resident falls were higher or additional measures including staffing were required. While the person in charge told inspectors staffing levels had being increased, the findings of this inspection indicated they were inadequate to meet the residents assessed needs of residents and to provide a quality service as documented in the statement of purpose document.

A number of actions had not been satisfactorily completed since the last inspection in July 2013 for example in care planning, provision of a high standard of evidence based nursing care, restraint management, fire safety management and provision of sufficient staffing levels. Findings on this inspection in outcome 8; Health and Safety and Risk Management, in outcome 11; Health and Social Care Needs and outcome 18; Staffing were in major non compliance with the Health Act 2007. Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Inspectors concluded that clinical leadership required significant and sustained improvement in the centre in order to be in compliance with the requirements of Health Act 2007. Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Judgment:**
Non Compliant - Major

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**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):**
No actions were required from the previous inspection.

**Findings:**
Written policies and procedures were not adequate to inform contemporary evidenced based practice. The centre's policies and procedures were provided to inspectors and reviewed accordingly. Most policy documents did not include an implementation or/review date. For example; the policy informing medication management made available to the inspectors did not contain a review or implementation date. Therefore, it was not clear whether the policy had been reviewed in the previous three years. While, reference documentation was available in the form of Department of Health publications for management of communicable infections, this information was not used to inform a
The centre's policy documentation available to inform infection prevention and control procedures did not adequately advise on management of communicable infections as found on this inspection. Policy documentation referencing nutrition did not inform or reflect practice in the centre and policy documentation informing protection of vulnerable adults was also inadequate. Protocols were not available or implemented to guide staff on use of 'as required' (PRN) psychotropic medication preparations.

The centre's health and safety statement was not reviewed on an annual basis and as such potential risks to residents and others found on this inspection were not identified with concomitant controls established to mitigate these risks.

There was evidence that residents may be at risk of unsafe or inappropriate care due to incompleteness of record keeping in relation to:
- daily monitoring of fire exits to ensure clear access is provided at all times,
- fortification procedures of meals for residents with unintentional weight loss,
- documentation in relation to on-going medical assessment, treatment and care provided by the residents' GPs
- any occasion on which chemical or physical restraint is used, the reason for its use, alternative interventions tried to manage the behaviour and the duration of the restraint.
- Inadequate resident records were maintained in the management of seizures.

The staff duty roster was not detailed in 24hr clock format and no time period was specified for staff working on night duty in the centre.

**Judgment:**
Non Compliant - Moderate

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**Outcome 07: Safeguarding and Safety**

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The policy document to inform protection of vulnerable adults in the centre was not dated and did not adequately inform prevention, recognition and management of incidents of elder abuse. The person in charge confirmed that there were no allegations of elder abuse reported or under investigation in the centre. Residents told inspectors that they felt safe and were complimentary of the staff caring for them. Staff - resident interactions were observed by inspectors on the days of inspection and were found to be...
satisfactory. Three staff members had not completed prevention of elder abuse training as per staff training records given to inspectors. However, staff spoken with by inspectors were aware of the procedures they should follow in the event of a disclosure.

While care plans were in place to meet the needs of residents with behaviour that challenged, these care plans were not adequately implemented by positive outcomes evidenced in practice. Documentation recording use of chemical and physical restraint was not in line with best practice procedures. Documentation reviewed by the inspectors did not verify that the use of 'as required' (PRN) psychotropic medication was in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health. Based on a sample of nursing and medical notes reviewed in conjunction with medication prescription charts, documented clinical indications were not identified that may trigger the use of PRN psychotropic medication. It was not clear if a medically identifiable condition was being treated. The nursing notes did not outline sufficient detail in relation to episodes where a PRN psychotropic medication was administered. A documented assessment was not completed prior to and after each instance that PRN psychotropic medication was administered. Protocols advising administration procedures for psychotropic medications on a PRN basis were not evident. While there was evidence that bedrail use for residents had been reduced, further improvement is required in this area to ensure bedrails used as restraints are the least restrictive measure used for the least amount of time and to ensure that the best interests of residents who do not have capacity to make informed decisions regarding bedrail use for them is promoted from a multidisciplinary perspective.

It was not clear from the documentation if PRN psychotropic medications were being used as a restrictive practice to manage behaviour that is challenging and if this behaviour was managed in the least restrictive manner.

**Judgment:**
Non Compliant - Moderate

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**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:**
There was evidence that systems were not in place to reduce and control antimicrobial resistance consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. Based on a sample of 27 medication
charts reviewed, 66% of residents had been prescribed a course of antibiotics in the previous six week period. This included repeat courses of antibiotics, including one record where a resident had received four courses of antibiotics within this period. There was no evidence of consultant microbiology input for residents requiring multiple antibiotics or radiology review for residents with respiratory tract infections being sought.

Antibiotic prophylaxis was prescribed to prevent urinary tract infections for 2 residents within the sample reviewed. This is not in line with national best practice guidance for antimicrobial prescribing in primary care.

Nursing staff with whom the inspectors spoke stated that they were not aware of a policy in place for the best usage of antimicrobials or clinical guidelines for antimicrobial prescription or usage within the centre. A policy was not included in the infection prevention and control policies made available to the inspectors during the inspection.

Most staff in the centre had attended training on infection prevention and control procedures. There was documented evidence of residents in the centre with communicable infections. While personal protective equipment (PPE) was provided and worn appropriately by staff, disposal of PPE procedures was not in line with best practice management of potentially hazardous waste materials. An open waste bin was observed by inspectors in place for waste collection in the bedrooms of each resident with documented communicable infections. Hand hygiene dispensers were located throughout the centre and placed within close proximity to rooms occupied by residents with communicable infections which inspectors were told by the person in charge were colonised. However, potential for spread to other residents was not adequately managed due to failure of most staff to carry out adequate hand hygiene procedures. In addition cleaning procedures for bedrooms of residents with documented communicable infections was not in line with best practice cleaning procedures and as such posed a risk of spread of infection to other residents.

The policy documents available to advise on management of communicable infection prevention and control management were not centre specific and therefore did not adequately advise staff on the procedures to follow in the centre.

The health and safety statement reviewed by inspectors was dated as last updated in 2012 and as such overdue for annual review. Inspectors found a number of potential risks to the health and safety of residents and others which were not documented as assessed with concomitant controls to mitigate level of risk posed. These risks included - risk of spread of communicable infection - risk posed by a toilet door which opens outwards into a corridor to a four bedded room. - sluice room door was found ajar - potentially hazardous cleaning solutions left unattended on the cleaning trolley in corridors frequented by residents and others - reconstituted cleaning solutions were not dated - some hand gel dispensers had spillage trays missing which posed a slip risk to residents from residue on floors.
Fire preventative measures were in place with evidence of up to date servicing of fire alarms and equipment in place, however there were omissions in the records for daily inspections of escape routes. Inspectors observed that a designated fire exit in the dining room was partially blocked by dining furniture. This finding was immediately addressed on notification of the provider by inspectors. Staff fire safety training and participation in fire drills were the subject of actions plans from the last inspection of the centre in July 2013 and were found to not be adequately completed on this inspection. Staff training records given to inspectors referenced that fourteen staff had not completed fire safety training for 2014, five of which had no record of completion of this mandatory training as per staff training records given to inspectors. The provider advised inspectors following this inspection that these records were not accurate as some staff referenced were on extended leave and arrangements were in place for training on their return to work. Staff spoken with were aware of the procedures for evacuating residents in the event of a fire occurring in the centre. Staff fire safety training included training on use of evacuation pads and each resident had a personal evacuation risk assessment completed. While there was some documentary evidence of staff participation in fire drills, confirmation of all staff having participated in twice yearly fire drills was not evident. Sixteen staff had not attended fire safety training for 2014, seven of which did not have documented evidence of having ever attended fire training in the centre as per staff training records given to the inspector.

Judgment:
Non Compliant - Major

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:
The policy on medication management was made available to the inspectors. Records were made available to the inspector which confirmed that staff had read and understood the policy. However, the inspectors noted that the policy did not contain an implementation or review date and is discussed in outcome 5 of this report.

Medications for residents were supplied by a local community pharmacy. There was evidence of appropriate involvement by the pharmacist in accordance with guidance issued by the Pharmaceutical Society of Ireland including quarterly review of prescribed medicine therapy in conjunction with nursing staff and the resident's GPs.

The inspectors noted that arrangements were in place for medication storage in a locked cupboard or medication trolley. However, the inspectors observed an unattended
medication trolley outside a communal area with medications left unsecured on top of the trolley accessible to a number of residents as they walked past the trolley. An inspector brought this to the attention of the staff nurse administering medications.

Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation. Medications requiring refrigeration were stored appropriately. However, the temperature of the medication refrigerator was not routinely monitored as required.

The inspectors observed medication administration practices and found that the nursing staff observed, did adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais with the exception of one incident of the medication trolley left unattended and unsecured.

Staff reported and the inspectors saw that it was not practice for staff to transcribe medication and no residents were self-administering medication at the time of inspection.

Medication management audits were completed regularly and results were made available to the inspectors. The inspectors were not satisfied of the validity of the audits as the audits did not identify issues which the inspectors identified during the inspection.

Documentation in relation to the use of PRN psychotropic medication did not record an assessment prior to use or the reasons for use; this finding is discussed further in outcome 7.

Records made available to inspectors confirmed that appropriate and comprehensive information was provided in relation to medication when residents were transferred to and from the centre. The inspector saw that medication incidents were identified and reported in a timely manner. There was evidence that learning from medication incidents was implemented.

An inspector examined a sample of medication prescription sheets and administration records for 27 residents. The medication prescription sheets examined were current. However, the inspector saw that a number of the medication prescription sheets examined did not contain a signature for each medication order. Therefore, these prescription orders were not complete authorisations to administer medications as per the Medicinal Products (Prescription and Control of Supply) Regulations (Amendment) 2007.

Medication administration sheets examined identified the medications on the prescription sheet, contained the signature of the nurse administering the medication and allowed space to record comments on withholding or refusing medications. The times of administration matched the prescription sheet.

Staff spoken with by the inspector spoke outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.
Judgment:
Non Compliant - Moderate

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

Findings:
There were 55 residents residing in the centre on the days of inspection, three of which were in hospital. Twenty residents had assessed maximum dependency needs, eleven had high dependency needs, nineteen had medium and three had low dependency needs. Each resident had evidence of needs assessment with corresponding care plans in place.

Care planning, provision of a high standard of evidence based nursing care and restraint management were found to be inadequate on the last inspection of the centre in July 2013 and were the subject of action plans not adequately completed as reflected by the findings of this inspection.

While some residents' care plans were personalised, the majority of the sample reviewed by inspectors were generic. Resident care plans were in pre-printed format with some individualisation done by addition of some text or/and selection of care interventions from a number of pre-printed care options presented. Inspectors found that this documentation format limited detail in some resident care interventions to meet individual assessed needs and subsequently care plans were not adequately detailed or personalised to inform care for individual residents with complex care needs.

Daily nursing notes provided evidence of some residents being managed in the centre with little evidence of positive outcomes in terms of improved health. Inspectors found that while input from General Practitioner (GP) was evidenced in nursing documentation, this input was not always timely or in the form of a consultation each time nursing staff sought medical intervention. GP input was recorded to frequently be in the form of faxed communications between the nursing home staff referencing residents' deteriorating health status to the relevant GPs and from the residents GPs back to staff in the centre instructing changes in treatments including antibiotic treatments. There was evidence that some residents were at an advanced stage of illness when transfer to
hospital for further care took place.

Care of residents with nutritional needs was not adequate. There was inadequate evidence available to support the needs of residents with specific dietary needs as recommended by the dietician were met. This finding is discussed further in outcome 15.

These findings were the subject of an immediate action plan issued to the provider and person in charge during feedback of inspection findings on 18 December 2014. The provider and person in charge responded as required on the 19 December 2014. This response did not adequately outline actions taken/proposed to ensure the health needs of residents were met and is repeated in the action plan at the end of this report.

As outlined in outcome 9, records were not available in relation to the temperature monitoring for the refrigerator used to store residents' medications. Nursing staff with whom the inspectors spoke confirmed that the temperature of the refrigerator used to store medication was not routinely monitored. There was no way of monitoring the reliability of the medication refrigerator, in line with professional guidance issued by An Bord Altranais agus Cnáimhseachais na hÉireann. Inadequate resident records were maintained in the management of seizures. Protocols were not available or implemented to guide staff on use of 'as required' (PRN) psychotropic medication preparations. This finding is discussed further in outcome 7.

There was evidence that systems were not in place to reduce and control antimicrobial resistance consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. Based on a sample of 27 medication charts reviewed, 66% of residents had been prescribed a course of antibiotics in the previous six week period. This included repeat courses of antibiotics, including one record where a resident had received four courses of antibiotics within this period. There was no evidence of consultant microbiology input being sought for residents prescribed for repeat antibiotic treatments. This finding is discussed in outcome 8 of this report.

Antibiotic prophylaxis was prescribed to prevent urinary tract infections for two residents within the sample reviewed. This is not in line with national best practice guidance for antimicrobial prescribing in primary care.

Nursing staff with whom the inspectors spoke stated that they were not aware of a policy in place for the best usage of antimicrobials or clinical guidelines for antimicrobial prescription or usage within the centre. A policy was not included in the infection prevention and control policies made available to the inspectors during the inspection.

Judgment:
Non Compliant - Major
Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
A comprehensive policy to advise staff on monitoring and documentation of residents nutritional well-being was not available. However, in practice, there was evidence that staff monitored residents' weight and recorded their intake. The needs of residents with swallowing difficulties were reviewed by specialist speech and language therapy services and recommendations made in relation to modification of food and fluid intake were adequately and accurately implemented.

Records of residents' food and fluid intake maintained by staff were referenced by a visiting dietician to estimate intake of residents with unintentional weight loss. The inspector reviewed copies of the most recent consultations by the dietician on 11 November and 08 December 2014 to support the nutritional health of five individual residents with confirmed unintentional weight loss, three of which had lost between 8.5% and 11.1% of their body weight in the three to six months previous to consultation. Copies of the dietician's recommendations were kept in the centre's kitchen to inform catering staff as appropriate. However, adequate evidence was not available to support implementation of recommendations made in terms of fortification of food by the dietician to ensure the nutritional needs of residents with documented unintentional weight loss were met. The inspector found that catering staff and staff supervising mealtimes were not adequately aware or informed of fortification procedures or of individual residents requiring this nutritional support as recommended by the dietician. A member of the catering staff told the inspector that all residents' potatoes were fortified with butter at kitchen level and that all milk used was low fat, however this practice did not meet the individual needs of some residents in the centre. There was no evidence of fortification of individual resident's food at the table. Although, cream was documented as a product that could be used for fortification of individual residents' food, a member of catering staff confirmed that this was not prepared or available at the lunch-time meal on the second day of this inspection.

The inspector observed a resident mealtime on each day of the inspection. While there was adequate staff in the dining room to assist residents with eating, assistance with eating was not provided discreetly to a resident on each day of the inspection. Inspectors found that records of food maintained by catering staff as provided for residents did not accurately reflect the menu displayed. While, inspectors were told that
alternative choice of dish was available to the single main course dish advertised, this was not evidenced on inspection. For example, a number of residents who refused to eat the main course provided for the lunchtime meal on the second day of the inspection were not offered the option of an alternative dish. Packs of moist wipes were available for residents' use at some tables during mealtimes. However, 95% of residents in the dining room wore protective bibs as observed by inspectors on the first day of inspection, disposable napkins were not provided as an alternative to clothes protectors to residents in the dining room during the mealtimes observed by inspectors. Staff told an inspector that clothes protectors were the choice of residents’ relatives. There was no evidence that residents who were able to make independent choices were afforded a choice of using a disposable napkin or a clothes protector.

The provider told inspectors that dining room chairs had been replaced recently. The new chairs were observed to promote resident accessibility and comfort. A dining table partially blocking a designated final fire exit in the dining room, notified by inspectors to the provider on the first day of inspection was rearranged immediately to provide unobstructed exit to resident if required in an emergency. Mealtimes were completed in one dining room sitting. The dining room had adequate dining facilities for 38 residents. This finding did not ensure that all 55 residents were afforded a choice to enjoy the dining experience in the dining room on a day to day basis if they wished. Some residents were observed to dine in the sitting rooms and reception area, which inspectors were told by staff was their choice. However, there was no documented evidence of this preference in individual resident's documentation or to be gleaned by completion of resident satisfaction surveys with their mealtime experience. This finding is discussed further in outcome 2 of this report.

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

Findings:
A copy of the staffing roster was provided to inspectors and reflected that there is a registered nurse on duty in the centre at all times. On the days of Inspection, this record accurately reflected the staffing within the nursing home.

Inadequate staffing levels and skill mix was the subject of an action plan from findings on the last inspection of the centre in July 2013 which was not adequately completed as evidenced on this inspection. An action plan requiring review of staff training to ensure care was provided in line with contemporary evidence based principles was partially met by implementation of a staff training programme however, the findings from this inspection provide evidence that best practice principles were not consistently applied.

Staff supervision procedures were not of a satisfactory standard with regard to provision of appropriate assistance to residents with eating in the dining room, insufficient fortification of residents’ meals as recommended by the dietician, absence of hand hygiene by staff, inadequate cleaning procedures and medications were accessible to vulnerable residents.

Inspectors found that the staff numbers and skill mix available were not sufficient to meet the needs of residents based on a review of documented resident accidents and incidents from January 01 2014 to June 30 2014 and from July 01 2014 to December 15 2014 completed by inspectors during the days of inspection. Inspectors found that 50% of resident falls occurred between 20:00hrs and 08:00hrs, 25% of which occurred in the three hour period between 20:00hrs and 23:00hrs. Of the five (25%) of resident falls documented as occurring within this three hour period, three which was 100% of all notifications of serious injury to residents notified to the Authority from 01 July 2014 to 18 December 2014. Two of these notifications referenced residents who sustained head injuries during a fall and were transferred by ambulance to the hospital emergency department for suturing of wounds to their heads. The third resident referenced sustained a suspected wrist fracture which was confirmed as a soft tissue injury following investigation in hospital. Inspectors also confirmed from the documented resident accident and incident records that 35% of adverse events involving residents occurred in the period between 12:45 and 16:20hrs. There was one staff nurse and four care staff rostered on night duty.

The centre's statement of purpose document referenced a high dependency facility accommodating four residents. Arrangements required for a high dependency facility as defined by the National Standards in terms of staffing levels and the assessed levels of dependency of residents residing there were not clearly evidenced from findings on inspection. The inspector observed that the staffing levels found did not reflect an adequate staffing level/skill mix to provide for the required '24 hour high support nursing care' in the area referenced as a high dependency unit, as described by the National Standards.

Staffing levels reduced to include one registered nurse and four care staff on duty at night. However on review of the dependency levels of residents, inspectors found that staffing levels and skill mix available were not sufficient to meet the needs of residents - to ensure the healthcare needs of residents were met when one registered nurse was on duty
- to care for residents in a 'high dependency' area as defined by the National Standards
- based on a review of documented resident accidents and incidents from January 01 2014 to December 15 2014,
- to ensure residents could be safely evacuated in the event of an emergency in the event of an emergency staff would be able to safely evacuate residents.

Therefore, due to the complex needs of residents in terms of care and monitoring requirements, findings where residents with advanced illnesses are cared for in the centre, evidence of increased falls, the layout of the centre over two floors and lack of documented evidence that all staff had participated in fire safety and simulated emergency evacuation drills to ensure residents could be evacuated safely by the number of staff on duty, inspectors concluded that these staffing levels or skill mix was not adequate to meet the needs of all residents in the centre.

Inspectors received the names and corresponding pin numbers for all staff nurses employed in the designated centre and confirmed that each were registered with An Bord Altranais up to 31st December 2014.

A staff training matrix was maintained and recorded staff attendance at training to support their professional development. However, training records confirmed that not all staff had attended mandatory training as required. There was also evidence that while staff attended training on topics to support and inform their practice, this training was not implemented in terms of evidence based best practice, for example, in restraint management, medication management and infection prevention and control practices and procedures.

**Judgment:**
Non Compliant - Major

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**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:**

Catherine Rose Connolly Gargan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mullinahinch House Private Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000148</td>
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<tr>
<td>Date of inspection:</td>
<td>17/12/2014 and 18/12/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>27/02/2015</td>
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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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
- The document was dated to cover the period 14 July 2010 to 13 July 2013 and was overdue for review.
- Staffing numbers were not accurate.

Action Required:
Under Regulation 03(2) you are required to: Review and revise the statement of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
purpose at intervals of not less than one year.

Please state the actions you have taken or are planning to take:
The statement of purpose has been revised and amended to reflect the management structures. It has additionally been amended to reflect that we have a four bedded unit and not a high dependency unit. We will review this document within the year and sooner should there be any changes in service provision.

Proposed Timescale: 01/02/2015

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:
The roles and responsibilities of other persons who were involved in the management of the centre were not explicitly defined to ensure that lines of authority and accountability were clearly established

Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The statement of purpose has been amended to reflect the management structure and lines of authority have been clearly documented within Mullinahinch House.

Proposed Timescale: 01/02/2015
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored were not adequate.

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:
We are currently conducting a review of tools to assess the standard of care. To date our main tools have been those surrounding dependency levels, falls and risk assessments. We have implemented several strategies to ensure patient safety and safe
delivery of care including a new audit of incidents and accidents. These span our medication delivery system where all medications are individually blistered reducing the number of potential medication errors. Our drugs are checked in by two Nurses on arrival to the Nursing home to ensure all doses are correct and as per medication kardex, independently of the checks completed by the pharmacy prior to delivery. We have recently introduced a new audit of non-blistered medications e.g. psychotropic medications and the circumstances of their use to ensure we meet all aspects of the standards related to medications. We have obtained copies of the audits completed by our Pharmacist which cover the ordering and returning of medications and will collate this information into our existing audits. We provided numerous ultra low specialised beds, equipment, floor sensor mats and seat sensor mats etc to reduce the number of falls since the introduction of new standards which were aimed at promoting a restraint free environment. We have reviewed all our actions regarding infection control in conjunction with our Clinical Nurse specialist, reviews include waste management, room cleaning, new centre specific policies for Infection Prevention & Control, Outbreak Management Policy and Antibiotic Policy document, training will be completed by the 30th of March.

**Proposed Timescale:** 30th March 2015 Training all other items 01 Feb 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:
Written policies and procedures reviewed by inspectors did not adequately inform contemporary evidenced based practice. Most policy documents did not include an implementation or/and review date.

Protocols were not available to advise staff on management of PRN medication and management of epileptic seizures

**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:
We have begun the process of reviewing all our policies to reference evidence based practice.

We have implemented new policies and procedures on
- Psychotropic medications
- The use of PRN Psychotropic medication
- Management of Epileptic seizures
- Draft house specific infection prevention and control guidelines
- Draft Outbreak management policy and guidelines
- Draft Guidelines for antibiotic usage

Page 20 of 30
Our prevention of elder abuse policy is currently under review. Training to take place on 20 & 21 March by a Postgraduate Education Co-ordinator from the HSE and the following topics

- Understand and define what is meant by the term “elder abuse”
- Understand and recognise different types and forms of elder abuse
- Understand and identify the factors and situations, including work and care practices, which can lead to elder abuse
- Understand and use the reporting system, when abuse is discovered or suspected

**Proposed Timescale:** 01/02/2015 Training 20/21 March

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Incomplete record keeping was evident in relation to;
- daily monitoring of fire exits to ensure clear access is provided at all times,
- fortification procedures of meals for residents with unintentional weight loss,
- documentation in relation to on-going medical assessment, treatment and care provided by the residents’ GPs
- any occasion on which chemical or physical restraint is used, the reason for its use, alternative interventions tried to manage the behaviour and the duration of the restraint.
- Inadequate resident records were maintained in the management of seizures.

The staff duty roster was not detailed in 24hr clock format and no time period was specified for staff working on night duty in the centre.

**Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
All staff have been advised on ensuring that all daily records are completed.
In the short term we have regular meetings with the Kitchen Staff to ensure that they know the importance of fortification of diets. In the long term we have appointed a Staff Nurse to coordinate and ensure fortification of diets have been completed and are actively seeking nutritional training courses that will facilitate her in carrying out this new role.
A new challenging behaviour monitoring chart has been implemented which requires Nursing staff to document all PRN psychotropic medication use and all alternative therapies utilised prior to its use.
A new template has been completed to detail the particulars of an epileptic seizure.
The staff duty roster is now in 24 hr format.
Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans in place to meet the needs of residents with behaviour that challenged were not adequately evidenced in practice. Documentation recording use of chemical and physical restraint was not in line with best practice procedures.

Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
A behaviour monitoring chart has being introduced to record behaviour that is challenging.

Proposed Timescale: 01/02/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Rationale for use of psychotropic medication was not recorded

Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
A policy and behaviour monitoring chart has been introduced to identify the rational for the use of psychotropic medication.

Proposed Timescale: 01/02/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy document to inform protection of vulnerable adults in the centre was not
dated and did not adequately inform prevention, recognition and management of incidents of elder abuse.

**Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**
This policy is currently being re-drafted

**Proposed Timescale:** 30/03/2015

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Three staff members had not completed prevention of elder abuse training as per staff training records given to inspectors.

**Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
The staff members noted above will attend training on the prevention of elder abuse.

**Proposed Timescale:** 22/01/2015

**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:
The health and safety statement reviewed by inspectors was dated as last updated in 2012 and was overdue for annual review. Inspectors found a number of potential risks to the health and safety of residents and others which were not documented as assessed with concomitant controls to mitigate level of risk posed. These risks included:
- risk of spread of communicable infection.
- risk posed by a toilet door which opens outwards into a corridor to a four bedded room.
- sluice room door was found ajar
- potentially hazardous cleaning solutions left unattended on the cleaning trolley in corridors frequented by residents and others
- reconstituted cleaning solutions were not dated.
- some hand gel dispensers had spillage trays missing which posed a slip risk to residents from residue on floors.
**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:**
- New waste management bins have been fitted in the appropriate rooms and new arrangements for waste collection from same arranged
- The health and safety statement has been updated
- An independent risk assessment by Olive Group Professionals did not identify any greater risk associated with an outward opening door compared with an inward opening door
- A new door closer has been fitted to the sluice room door
- A new system for cleaning has been implemented where individual mop heads are used for each room and en suite
- New spillage trays have been installed to the automatic hand hygiene dispensers

**Proposed Timescale:** 01/02/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was evidence that systems were not in place to reduce and control antimicrobial resistance consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Nursing staff with whom the inspectors spoke stated that they were not aware of a policy in place for the best usage of antimicrobials or clinical guidelines for antimicrobial prescription or usage within the centre. A policy was not included in the infection prevention and control policies made available to the inspectors during the inspection.

**Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**
A new policy will be developed with the assistance of our infection control consultant and will be implemented in the home. Appropriate training will be provided to all staff.

**Proposed Timescale:** Policy in place since 01/02/2015, 30/03/2015 for training completion

**Theme:**
Safe care and support
| The Registered Provider is failing to comply with a regulatory requirement in the following respect: |
| There were omissions in the records for daily inspections of escape routes. |

**Action Required:**
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**
Staff have been reminded of the importance of completing these daily records.

| Proposed Timescale: 01/02/2015 |
| Theme: Safe care and support |

| The Registered Provider is failing to comply with a regulatory requirement in the following respect: |
| While there was some documentary evidence of staff participation in fire drills, confirmation of all staff having participated in twice yearly fire drills was not evident. |

Documentary evidence provided did not confirm that all staff had attended fire safety training for 2014.

**Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**
The number of staff quoted here is incorrect. Details have been forwarded to the Inspectorate as requested. All fire training is now up to date.

| Proposed Timescale: 17/01/2015 |

| 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: |
| A medication trolley with unsecured medications was observed to be left unattended. |

**Action Required:**
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.
Please state the actions you have taken or are planning to take:
All staff nurses have being instructed to lock medication trollies when unattended during medication rounds.

Proposed Timescale: 19/12/2014

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of medication prescription sheets did not contain a signature for each medication order as per the Medicinal Products (Prescription and Control of Supply) Regulations

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:
We have requested and will continue to request for residents GPs to sign all medication prescription sheets.

Proposed Timescale: 01/02/2015

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The reliability of the medication refrigerator was not recorded in line with professional guidance issued by An Bord Altranais agus Cnáimhseachais na hÉireann.

Preprinted care plan documentation format limited detail in some resident care interventions to meet individual assessed needs and subsequently care plans were not adequately detailed or personalised to inform care for individual residents with complex care needs.

Some residents at an advanced stage of illness did not have timely transfer to hospital for further care.

GP referral was not always timely and input was not always in the form of a consultation each time nursing staff sought medical intervention.
Care of residents with nutritional needs was not adequate.

**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:**
- A temperature recording chart is now in place to record the reliability of the medication refrigerator.
- Care plans are under review to make them more personalised.
- We have raised the inspectors concern surrounding GP care and faxed communication, and they will attend to the residents needs in a reasonably practical time frame.

**Proposed Timescale:** 01/02/2015

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence of consultant microbiology input being sought for residents prescribed for repeat antibiotic treatments.

There was a lack of documentary evidence to support that access to the residents GP was timely and input was in the form of an appropriate on-site consultation when nursing staff sought medical intervention for residents.

**Action Required:**
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

**Please state the actions you have taken or are planning to take:**
There is no community microbiologist in the Cavan/Monaghan area. The standard requires the provision of this service “in so far as is reasonably practicable”. We will refer our antimicrobial concerns to the Microbiologist in Cavan Hospital but cannot guarantee that we will be facilitated in same.

**Proposed Timescale:** 30/03/2015

**Outcome 15: Food and Nutrition**

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**
in the following respect:
Adequate evidence was not available to support accurate implementation of recommendations made in terms of fortification of food by the dietician to ensure the nutritional needs of residents with documented unintentional weight loss were met. Catering staff and staff supervising mealtimes were not adequately aware or informed of fortification procedures or of individual residents requiring this nutritional support as recommended by the dietician.

Although, cream was documented as a product that could be used for fortification of individual residents’ food, this was not prepared or available.

Action Required:
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
A review of all residents on fortified diets has been carried out with our catering team and changes have being implemented. Nursing staff have been instructed to continually monitor residents on fortified diets. New menus which includes a choice are currently under review by a dietician

Proposed Timescale: 30/03/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Arrangements and floor space in the dining room did not ensure that all 55 residents were afforded a choice to enjoy their dining experience in the dining room on a day to day basis if they wished.

Choice of dish was not offered to residents at each mealtime as one main course and one dessert option was prepared.

Residents were not provided with a choice of disposable napkin as an alternative to the use of clothes protectors.

Some residents were not provided with appropriate assistance

Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
A choice of dish will now be provided
Napkins are available to Residents
A review of staffing levels and training at meal times will be conducted to ensure appropriate assistance is offered to the Residents

**Proposed Timescale:** 01/02/2015

### Outcome 18: Suitable Staffing

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<th>Theme: Workforce</th>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Staffing levels and skill mix available were not sufficient to meet the needs of residents:
- to ensure the healthcare needs of residents were met when one registered nurse was on duty
- based on a review of documented resident accidents and incidents from January 01 2014 to December 15 2014,
- to meet the requirements for a four bedded area referred to in the centre's statement of purpose as a 'high dependency' area
- to ensure residents could be safely evacuated in the event of an emergency.

**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 re-categorised our high dependency unit to a four bedded unit and have amended our statement of purpose to reflect same.

We will review our staffing levels and skill mix and are sourcing an appropriate tool to do same.

**Proposed Timescale:** 30/03/2015

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training records confirmed that not all staff had attended mandatory training as required. Staff training attended to support practice was not implemented in terms of evidence based best practice.

**Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**
All staff members have attended mandatory training. We will continue to provide staff with all appropriate training and will endeavour to keep our records of same up to date.

**Proposed Timescale:** 01/02/2015

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff supervision procedures was found to not be of a satisfactory standard with regard to observed inappropriate assistance provided to residents with eating in the dining room, insufficient fortification of residents' meals as recommended by the dietician, care of residents, absence of hand hygiene by staff, inadequate cleaning procedures and medications accessible to vulnerable residents.

**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:**
We will pilot a new dining experience for our residents with two sittings for meal times. Two Month Trial
As stated in outcome 15 a review has been completed and implemented for the fortification of residents diets 01/02/2015
All staff have been advised of the importance of hand hygiene 01/02/2015
Cleaning procedures are under reviewed and recommendations from our infection control consultant will be implemented 30/01/2015

**Proposed Timescale:** 01/02/2015