# Health Information and Quality Authority

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Park Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000435</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Plassey Road, Castletroy, Limerick.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>061 332680</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:pshanahan@mowlamhealthcare.com">pshanahan@mowlamhealthcare.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Mowlam Healthcare Services</td>
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<tr>
<td>Provider Nominee:</td>
<td>Pat Shanahan</td>
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<tr>
<td>Lead inspector:</td>
<td>Gemma O'Flynn</td>
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<tr>
<td>Support inspector(s):</td>
<td>Julie Hennessy</td>
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<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>56</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</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.
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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 24 February 2015 09:00  
To: 24 February 2015 18:10

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

<table>
<thead>
<tr>
<th>Outcome 02: Governance and Management</th>
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<tbody>
<tr>
<td>Outcome 03: Information for residents</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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</table>

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection to monitor ongoing compliance with the Regulations. As part of the inspection process, inspectors met with residents, relatives, staff, the clinical nurse manager (CNM), the person in charge and the provider. Practices, procedures and documentation were also reviewed.

Overall, residents indicated that they were happy, safe and well cared for in the centre. Relatives said that they were happy with the care delivered in the centre and could approach any member of staff if any issues arose. There was evidence of good practice, however, areas requiring improvement were identified. These included staffing, which had a major non compliance, resulting in an immediate action and required a response from the provider prior to the close of the inspection. Other areas of non compliance were identified in Governance & Management (Outcome 2); Safeguarding & Safety (Outcome 7); Health & Safety (Outcome 8) and Health & Social Care Needs (Outcome 11).

The findings of the inspection are discussed throughout the report and in the action plan at the end of the report.
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:
There was a clearly defined management structure that identified who is in charge and accountable and what the reporting structure was.

There was a system in place to ensure that the service provided was safe and appropriate to residents’ needs. This included audits such as resident personal hygiene, catering, control of medication & administration and falls. A range of comprehensive data was gathered as a result of these audits, however it wasn't always clear how the information that had been gathered was contributing to an improvement in the services provided. For example, following collection of a range of data regarding falls, it was not evident what plan was in place following analysis of this data to try and reduce to number of falls for the next quarter where possible.

Audits relevant to particular issues in the centre had not been undertaken. For example, there were no systems in place to monitor compliance with national guidelines and policies in relation to isolation procedures and hand hygiene. Also, the number, type and source of Healthcare Associated Infections (HCAIs) were not recorded, monitored or audited. No analysis of HCAIs had taken place. This is discussed further in outcome eight.

There was evidence of regular management and staff meetings being held in the centre. A staff meeting had been held in January 2015 and covered matters such as communication, laundry, training, care issues and policies. Health and safety meetings were held in the centre, the most recent being in January 2015. There was evidence of catering meetings and meetings with senior carers.

Resident meetings were also held in the centre. The clinical nurse manager (CNM) stated that she chaired these meetings. The CNM stated that the most recent meeting
had been held in December 2014. On the day of inspection, minutes were reviewed for a meeting held in September 2014. Each issue raised had a response by management in regards to what action would be taken. It wasn’t clear what consultation occurred between residents and management about the development of the activities programme to ensure activities were meaningful the residents. The person in charge told the inspectors that residents were consulted in this regard, however, other staff were not able to demonstrate an awareness of this consultation process. Some staff told inspectors that they would like to see a more varied activities programme in the centre and a resident told the inspector that the day’s activity was not to her taste. Activities are discussed further under outcome 11.

**Judgment:**
Substantially Compliant

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**Outcome 03: Information for residents**

_A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged._

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
One aspect of this outcome was examined on this inspection in follow up to an action required of the provider following the centre’s previous inspection in November 2013. On this occasion, the inspector found that the contracts of care detailed the fees to be charged to the resident.

**Judgment:**
Compliant

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**Outcome 04: Suitable Person in Charge**

_The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service._

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
There was a person in charge of the designated centre. She was a qualified nurse with the required experience in the area of nursing of the older person. She was engaged in the governance, operational management and administration of the centre on a regular and consistent basis. Residents could identify her and staff were supportive of her stating that she was approachable and a presence in the centre.

She had completed some training to enhance her continuing professional development in 2014. This related to managing specific scenarios when working with residents with dementia. She had attended a provider's seminar run by the Authority in February 2015 and spoke of plans to ensure that activities were meaningful in 2015 such as increasing outings and arranging visits to the centre by local groups / educational centres.

She told the inspector that she had regular interaction with the regional operations manager and there were no barriers in communicating with the provider.

Judgment:
Compliant

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:
Measures to protect residents from being harmed or suffering abuse were in place in the centre. The inspector found that improvements were required in relation to the promotion of a restraint-free environment and to the documentation pertaining to the management of behaviours that challenge.

The inspector spoke with residents who said that they were happy and felt safe in the centre. Residents said that they would be comfortable to raise any concerns they had with the person in charge, CNM or senior staff on duty. The inspector spoke with a relative who said that she was happy with the care being received by her loved one, would be comfortable to raise any concerns and that any issues raised were promptly addressed. The inspector spoke with staff who said that there were no barriers to reporting suspicions, incidents or allegations of abuse. All staff had received mandatory training in relation to elder abuse.
The inspector spoke with staff who were able to articulate how to respond and support residents with behaviours that challenge. Care plans had been developed for residents with behaviour that challenges. The inspector reviewed a sample of such care plans and found that improvements were required. Residents with behaviours that challenge did not have a behaviour management plan that clearly set out the reason behind such behaviours, possible triggers and how to respond to such behaviours in a step-by-step manner. This will be further addressed under Outcome 11 and in the associated action.

The inspector found that there were a high number of bedrails in use in the centre. 22 of the 56 residents had bedrails in place. The person in charge did not demonstrate that sufficient efforts had been made to explore alternatives to the use of bedrails. Consent and risk assessments were available for the use of bedrails, as required. For two residents however, the use of bedrails had been requested by relatives, which is not in line with national policy. Furthermore, although the inspector was informed that staff carried out two-hourly checks of all residents throughout the night, such checks for residents with bedrails in use was not documented as required. Four residents had lap-belts in use. The inspector reviewed a care plan for one resident with a lap-belt in use and found that the care plan documented the rationale for the lap-belt and the safe management of the use of the lap-belt. The lap-belt was released every two hours, as required for any physical restraint and this was documented. However, it was not evident what alternatives had been considered to the use of the lap-belt.

A small number of staff had received training in the management of behaviours that challenge. This training was outstanding for most staff and is required by the Regulations. This training deficit will be addressed in outcome 18.

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):
No actions were required from the previous inspection.

Findings:
The centre had policies relating to health and safety and a safety statement dated July 2014 was in place. A risk management policy was also in place, however, it did not meet the requirements of the Regulations as the arrangements for managing abuse were not included. This was amended by the person in charge prior to the close of the inspection.

There was arrangements in place to prevent accidents in the centre, however, not all
hazards had been identified such as the stairwells in the centre and the fact that staff were on call to respond to emergencies relating to others not residing in the designated centre. It was evident that the centre was proactive in trying to identify new hazards in the centre, however it was not clear that appropriate action was taken in all instances. For example, the health and safety committee had identified in January that a fire extinguisher in a room upstairs was obstructed by a bin. This was still an issue on the day of the inspection. Incidents were recorded electronically and the inspector reviewed an example of this. It included opportunities to consider pharmacological or external factors contributing to the incident and provided an opportunity for learning from the incident.

The inspector found that the systems in place for the prevention and control of healthcare associated infections (HCAIs) required improvement.

The clinical nurse manager (CNM) had sought advice from competent persons (a consultant microbiologist and infection control nurse) in relation to the management of specific healthcare associated infections. As a result, a number of measures were in place including the use of personal protective equipment, dedicated seating and cushions, the management of potentially contaminated waste and linen. Single rooms with ensuite shower and toilet facilities were available where required. Hand hygiene facilities and equipment were available including hand wash sinks, hand gel, soap dispensers and clear and easy to understand signage.

The CNM delivered hand hygiene training and had completed a 'train the trainer' course. There was no staff member with recognised qualifications, competencies or skills in the area of infection control in the centre, although the CNM and person in charge confirmed that they had access to such input if required. Staff had not received infection control training, including in relation to the management of specific HCAIs.

The inspector found that hand hygiene practices that prevent, control and reduce the risk of the spread of HCAIs were not in accordance with best practice guidelines. The inspector observed four staff entering and leaving 'isolation' rooms and found that all four staff missed at least one hand hygiene 'moment'. The inspector also talked to staff about their understanding of how to manage residents presenting with a HCAI and found that staff were inconsistent in their responses about when to wash their hands. A number of staff told the inspector that they were unclear about what procedures to follow in relation to the management of residents presenting with a HCAI.

A care plan had not been completed for residents with a HCAI, so as to direct the specific care to be given to each resident.

The systems in place to manage and control the spread of communicable/transmissible disease required improvement. For example, there was no systems in place to monitor compliance with national guidelines and policies in relation to isolation and hand hygiene. Also, the number, type and source of HCAIs were not recorded, monitored or audited. No analysis of HCAIs had taken place.

Overall, the physical environment was clean and cleaning staff were employed in the centre. Additional cleaning measures had been put in place for the management of
seating and cushions. However, the systems in place in relation to environmental cleaning required review to ensure that they were in line with best practice.

Residents’ linen was sent off-site and personal laundry was managed in-house. Arrangements in place for the management of personal laundry required review to ensure that they were in line with best practice.

There were systems in place for the management of waste, including hazardous/clinical waste. Dedicated waste bins for hazardous waste and ‘sharps’ bins for the safe disposal of sharp items were provided.

Records showed that staff were trained in people moving and handling. Overall, good practice was observed. Staff were seen to use the equipment provided. However, there were occasions whereby outdated and unsafe techniques were seen to be used.

There was suitable fire equipment provided and service records were maintained for same. Fire exits were unobstructed and daily checks of exits were carried out. Records were maintained of these checks. Some staff were not up to date with mandatory fire training, this is discussed further in outcome 18. Records indicated that fire drills were carried out regularly, however there was an opportunity to improve the documentation of these drills, to enhance learnings and improve staff response in the event of a fire in the centre. This was discussed with the person in charge.

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:
There were written policies relating to medication management in the centre. Appropriate practices and procedures, in line with professional guidelines, were in place for the handling of medicines including controlled drugs. There were systems in place to ensure delivery of residents’ monthly prescriptions to the centre were checked as being correct by two staff members.

A medication round was observed and practice was found to be compliant with professional guidelines. Procedures for the transcribing of medication were in place and appropriately implemented. There were appropriate procedures for the handling and disposal of unused or out of date medication.
Medication errors were recorded if they so occurred and included a description of the incident, action required and contributing factors.

**Judgment:**
Compliant

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**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:**
Residents' health care needs were met through timely access to medical treatment. Residents had the option of retaining their own General Practitioner (GP) or could transfer to the care of other GPs visiting the centre if they so wished. Residents had access to allied health professionals such as physiotherapists, occupational therapists, dieticians, optician and dentist. The clinical nurse manager (CNM) was able to discuss the referral process for each of these health professionals.

Care delivered encouraged early detection and prevention of ill health such as monthly blood pressure, weight and blood sugar recording. Records viewed evidenced that these measures were implemented.

Practices were observed whilst staff interacted with residents in communal areas and all interactions were seen to be respectful and appropriate. Staff were seen to encourage the resident’s independence if they were assisting with specific tasks.

Assessments were carried out on a four monthly basis and were seen to be update in the records viewed. Assessments included nutritional status, risk of falls, mobility assessment amongst others.

A sample of care plans were reviewed. Not all had been reviewed on at least a four monthly basis as per the Regulations. For example, one plan seen had not been reviewed since August 2014 and the care specified in the plan was no longer relevant to the resident's daily care. In another care plan for a resident with mobility needs, it wasn't clear to what extent her mobility was impaired. For example, it wasn't clear whether or not the resident could weight bear for transfers or needed specific
equipment. The resident’s manual handling assessment did not correlate with his/her care plan. Where a specific intervention had been implemented, for example, a nutritional intervention, the rationale was not evident.

Staff were able to discuss the specific care of resident who exhibited behaviours that challenge. However, residents with behaviours that challenge did not have a behaviour management plan that clearly set out the reason behind such behaviours, possible triggers and how to respond to such behaviours in a step-by-step manner, to ensure that all staff responded in a consistent and appropriate way.

A sample of care plans relating to end of life care were reviewed. The standard of information was not consistent in all care plans. Some care plans gave a comprehensive overview of what the resident wishes and needs were, for example, plans guided staff as to what clothes a resident would like, music they had chosen and tasks they would like their family member to complete. However, some plans did not adequately outline residents wishes or needs, although the CNM was able to discuss in some detail what the resident would like, care plans did not always reflect this.

As discussed in outcome eight, care plans were not in place for residents who had required Health Care Associated Infections (HCAI).

A range of activities were seen to be in place on the day of inspection such as snakes and ladders and an outing to a local educational centre that was running an event for older persons in designated centres and the community. One resident told inspectors that the activity on offer didn't appeal to her, and as discussed in outcome two, some staff told inspectors that they would like to see some variety in the activities schedule. There were opportunities for residents to engage with each other socially and an upstairs seating area was seen to be a popular gathering spot for residents to get together for a chat before lunch. In the afternoon, the inspector observed a great atmosphere in the lobby area where residents were awaiting transport for the afternoon’s outing.

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:
The centre's staffing levels were determined based on the needs of the designated centre's residents. However, over the course of the inspection, inspectors were made aware that the centre provided an on call emergency response service for people not residing in the designated centre. This regularly resulted in two staff being absent from their duty in the designated centre, for undetermined timeframes, so as to attend to the needs of the persons residing in the non designated centre.

Inspectors were therefore not satisfied that the registered provider had ensured that the number and skill mix of staff was appropriate at all times, having regard to the needs of the residents and the size and layout of the designated centre. An immediate action was issued to the provider in this regard.

Some gaps were noted in mandatory training. As discussed in outcome eight, not all staff had received fire training and only a small number of staff had received training in the management of behaviours that challenge.

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:

Gemma O'Flynn
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 report

<table>
<thead>
<tr>
<th>Centre name</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000435</td>
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<tr>
<td>Date of inspection:</td>
<td>24/02/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>12/03/2015</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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It wasn’t always clear how the information obtained following audits was contributing to an improvement in the services provided.

Audits of issues pertinent to the centre had not been undertaken, for example, there were no systems in place to monitor compliance with national guidelines and policies in relation to isolation procedures and hand hygiene.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
It wasn't evident as to how residents were consulted in regards to their specific preference for activities on offer.

**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:**
Activities will be a defined agenda item on Residents meetings – this practice has commenced.

Activities satisfaction Survey will be carried out.

Audits will be completed every 3 months and these will include action plans based on areas of non-compliance in line with company policy, including hand hygiene, infection control and HCAI's. Any outstanding actions are identified through the MAMS (auditing) system will be appropriately addressed in a timely manner.

The National Hand Hygiene Audit template will be used to audit compliance with Hand Hygiene guidelines on a 3 monthly basis.

Weekly monitoring of infections in the home is identified on the Clinical Nurse Manager report to the DON and the DON Management report to Head Office.

Infection control has been included a standing item on the monthly home management meeting.

An Infection Control Surveillance Matrix will be developed which will inform staff of all current infections in the home.

**Proposed Timescale:** 30/05/2015

**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:**
The use of restraint was not fully in line with national policy, for example:
It was not evident what alternatives had been considered to the use of lap-belts in the centre.
Nor was it demonstrated that sufficient efforts had been made to explore alternatives to the use of bedrails.
Bedrails were in use for two residents on request of their relatives.

**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 review of the risk assessments and care plans of all residents currently using bed rails and lap belts has recently been completed and was undertaken in accordance with National Guidelines.

All documentation including 2 hourly check lists is now in place as identified by the National Policy guidelines.

Proposed Timescale: 24/03/2015

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 hazard identification process was not robust in that in did not identify all hazards in the centre.

Where hazards had been identified, they had not always been addressed appropriately.

Outdated and unsafe moving and handling practices were seen to be used in the centre.

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:
The identified Hazards as outlined at the Inspection have been risk assessed and action plan as appropriate completed.

Upskilling in the use of handling belts has been completed by all staff.

Supervision and observation of manual handling practices will be monitored on an ongoing basis by Clinical Nurse Manager, nursing staff and senior care assistants.

Proposed Timescale: 28/02/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
Procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were not fully implemented by staff. Arrangements in place for the management of residents' personal laundry required review. The systems in place in relation to environmental cleaning required review. The systems in place to manage and control the spread of communicable/transmissible disease required improvement. Hand hygiene practices that prevent, control and reduce the risk of the spread of HCAIs were not in accordance with best practice guidelines. Staff were unclear about what procedures to follow in relation to the management of residents presenting with a HCAI.

**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:
Cleaning and laundry procedures have been re-issued and these include the management of HCAI’s in line with the Mowlam Infection Control policy, HSE National Cleaning Standards and the National Standard for the Prevention and Control of Healthcare Associated Infections (HCAIs) (2009).

Further Hand Hygiene and Infection Control training to include the management of HCAI’s will be provided for all staff.

Specific care plans for residents with diagnosed HCAI’s have been completed.

**Proposed Timescale:** 30/05/2015

**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:**
Care plans were not always reviewed at least four monthly.
Care plans had not been reviewed where required, for example, if a resident acquired a HCAI.

Residents with behaviours that challenge did not have a behaviour management plan that clearly set out the reason behind such behaviours, possible triggers and how to respond to such behaviours in a step-by-step manner, to ensure that all staff responded in a consistent and appropriate way.
Assessments didn't always correlate with care plans, for example, manual handling assessments and the associated mobility care plan.
Where specific interventions were implemented, the rationale was not always evident.
End of life care plans were not consistent in the documentation of residents' specific end of life wishes.
**Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**
The outdated Care Plan identified has now been reviewed and updated in line with Regulation 05(4).

Specific care plans for those identified with HCAI’s have been developed and implemented.

Residents identified with challenging behaviour will have appropriate care plan in place.

End of Life care plans will continue to be developed with the agreement of the individual resident with input from the family. In the event that a resident chooses not to discuss end of life preferences, this will be documented in the care plans.

**Proposed Timescale:** 30/05/2015

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre’s staffing levels were determined based on the needs of the designated centre’s residents. However, over the course of the inspection, inspectors were made aware that the centre provided an on call emergency response service for people not residing in the designated centre. This regularly resulted in two staff being absent from their duty in the designated centre, for undetermined timeframes, so as to attend to the needs of the persons residing in the non designated centre.

Inspectors were therefore not satisfied that the registered provider had ensured that the number and skill mix of staff was appropriate at all times, having regard to the needs of the residents and the size and layout of the designated centre.

**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:**
The Protocol for Emergency Call-out has been revised.

Telephone Triage for all emergency calls as the first step of the protocol. This will
significantly reduce the number of true emergency call-outs.

An additional staff member has been added to the staffing complement on the duty rota from 8pm-8am who has First Aid certification. This person is the designated responder to emergency call-outs. The staff member is surplus to the required number of staff to meet the needs of the residents in the centre. This arrangement will be monitored closely and reviewed if necessary to ensure that there is no occasion whereby staff allocated to meet the needs of the residents in the centre will be absent from the centre in order to attend to the needs of those in a non-designated centre.

Risk Assessment Completed.

**Proposed Timescale:** 24/02/2015

**Theme:**

Workforce

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

Not all staff were up to date with mandatory training, for example, fire training and training in the management of behaviours that challenge.

**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:**

A full review of the Fire Training Records was undertaken and correlated with the Training Matrix- there are 69 staff members and 10 staff have training outstanding; of those 10: 3 are currently on Maternity Leave and 2 are on long term sickness leave. They will be required to complete fire safety awareness upon returning to work and will be required to attend formal fire training also. Training has been scheduled for remaining staff members. All new staff have completed fire safety awareness as part of induction and orientation.

Challenging Behaviour Training:

Challenging Behaviour training will be undertaken by our Practice Development Facilitator for all outstanding staff who require this training.

**Proposed Timescale:** 01/05/2015