Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St Gabriel's Nursing Home
Centre ID:	OSV-0000174
Centre address:	Glenayle Road, Edenmore, Dublin 5.
Telephone number:	01 847 4339
Email address:	nursingstgabriels@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	SGNH Limited
Provider Nominee:	Helen Jones
Lead inspector:	Leone Ewings
Support inspector(s):	Jim Kee;Sheila McKevitt
Type of inspection	Unannounced
Number of residents on the date of inspection:	62
Number of vacancies on the date of inspection:	4

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 inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 February 2015 11:30	13 February 2015 19:00

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

Outcome 02: Governance and Management
Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 15: Food and Nutrition
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was an unannounced inspection which took place over one day and was for the purpose of monitoring progress further to eight non-compliant outcomes from the registration inspection of 18 and 19 November 2014 and informing an application to renew the registration of the designated centre. The initial action plan response to this inspection report was not satisfactory, and a further action plan submitted was not found to be robust to fully address non-compliances.

Four monitoring events took place during 2013 to monitor and review care provision at this centre; 7 March 2013, 24 July 2013, 19 August 2013 and a thematic inspection which took place on 19 November 2013. All of the action plans relating to non-compliances were followed up during the last registration inspection in order to ascertain current compliance to 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. From a risk management perspective the Authority was not satisfied that at the time of this inspection sufficient governance was in place to effectively make the improvements required to ensure safe service provision.

The centre was purchased by this provider in 2012 as a designated centre for older

persons and the provider has applied for renewal of registration for 66 places. The provider operates as a limited company and consists of four directors. The provider nominee appointed in 2013 by the company is not a company director and also works in the role as the person in charge. Changes had taken place to the provider nominee since the time of the initial registration process, and the Authority had been provided with full and complete information on the new provider nominee. She had been interviewed at the time of this change to ascertain fitness to undertake the role and responsibilities therein.

This report sets out the findings of this follow up inspection and review of unsolicited information relating to care and welfare concerns about health and social care needs of residents. The Authority was in receipt of information relating to risks regarding nutritional assessment and supervision at mealtimes. The provider was found to have completed the investigation into the concern relating to a long term resident and a draft report of the investigation submitted to inspectors with a number of recommendations for quality improvements to practice. A review also took place of all the statutory notifications submitted to the Authority, inclusive of an allegation of psychological abuse and a serious incident reported by the provider. However, the provider had not submitted an update on this notification as required after 20 working days.

The management team had or were in the process of addressing some of the non-compliances further to the last inspection on 18 and 19 November 2014. However, the current management systems were not found to be fully effective and were not fully addressing the regulatory improvements necessary to address quality and safety in a robust way.

The inspector found that improvements were necessary relating to how the service managed and addressed all non-compliances. This judgment was based on the findings of this follow-up inspection and clinical governance issues identified during this and the last inspection in November 2014. On this inspection there were non-compliances in nine of the nine outcomes reviewed on this follow up inspection. Inspectors were concerned about the absence of the risk register and risk management, governance, staffing, documentation of clinical care, failure to notify pressure ulcer, and the standard of reporting following an investigation into a safeguarding incident.

The inspectors found that overall the health needs of residents were met. However, the standards of documentation relating to resident assessment and care planning was not robust or in line with best practice. Improvements were required relating to provision of adequate dining space, and further review of the communal day space provision available to residents was necessary.

Staffing provision was reviewed further to the last registration inspection based on feedback from respondents to the relative and resident questionnaires regarding concerns about the adequacy of supervision and staffing levels, a further health care assistant was rostered during the day on the first floor. Some concerns were voiced to the inspector by a number of relatives relating to changes in the service provision and staffing of the centre at the time of the last inspection. Staffing and supervision

arrangements had improved, but further review of staffing at the designated centre was necessary particularly relating to the ongoing use of agency and relief nursing staff. A detailed review involving an external consultant had taken place during October 2014 and the provider nominee had a plan to address the recommendations made. A risk management policy was submitted further to the last registration inspection and further training was identified and scheduled for clinical nurse managers in risk assessment. A clinical governance group is now in place and meets every two months, and external mentoring supports are in place for the management team. Staff had a good knowledge of residents and their individual needs and provided care.

Areas for improvement identified included the governance, documentation of safeguarding investigations, recording clinical care, and staffing . Although staffing levels were found to be generally adequate on the day of the inspection improvements were required relating to competencies of registered nursing staff and supervision of clinical care and documentation.

These areas for improvement are discussed further in this follow up-report and are included in the action plans at the end of this report

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

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
The provider has reviewed management systems in place, since the time of the last inspection on 18 and 19 November 2014. It is acknowledged by inspectors that the current management have sought input, and additional external training and consultancy to support the current arrangements. However, these inputs had not been fully effective in making the changes necessary to implement and deliver safe, quality care services, and address non compliances. The agreed time frame to complete a review of resident quality of life was the end of May 2015 to link in with the review of quality and safety report completed by external consultants during October 2014.

The inspectors acknowledged work commenced particularly relating to the commencement of clinical governance and development of an audit programme. The risk register was not up to date and clinical nurse managers had yet to receive the relevant risk management training and clinical governance experience to fully review meaningful analysis of any data collected and mitigate further risks to residents.

The current management and governance systems were found not to be fully effective thus leading to some poor outcomes for residents. The provider's response to the registration inspection had stated that mentoring for senior management would commence and clinical governance meetings would take place. The inspectors found that the first clinical governance meeting had taken place on 3 February 2015 and were scheduled to take place on a two monthly basis. The minutes of this minutes did not sufficiently prioritise or risk assess actions or allocate responsibility or accountability for all of the actions identified for improvement or identify resources required as discussed in Outcome 8 of this report.

The role of the person in charge who was also the provider nominee and her additional

responsibilities since 2013 have not been adequately examined or reviewed by the directors of the provider entity. A member of the board of directors attended the feedback from this inspection and this finding was clearly communicated by the inspectors for action by the board of directors.

Judgment:
Non Compliant - Major

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The risk management policy had been revised by the provider within the agreed time frame, and submitted as part of the action plan response to the Authority. The policy is detailed and more centre specific to the designated centre. However, aspects of this policy have not yet been fully implemented as outlined in Outcome 8 of this follow up report.

The risk assessment documentation for residents living at the centre who smoked was found to be comprehensive and fully completed by nursing staff and kept under review.

The inspectors noted that the information held on the electronic directory of residents was not easily retrievable by staff. For example, details of residents transferred to hospital, and deaths.

Judgment:
Substantially 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:
Further to the last inspection the Authority received a notification from the provider which reported allegations of psychological abuse was being investigated. The inspector was satisfied that all residents' rights were safeguarded during the investigation process.

However, the methodology of the investigation and manner in how the facts were established and reported could be improved, to include records of any interviews conducted and statements from staff on duty at the time of the alleged incidents. The inspectors also found that no record could be found of the resident's next of kin being informed of this matter in a timely manner.

Aspects of how the facts were established during the investigation and the outcome and regulatory requirements relating to record keeping were discussed with the provider at feedback. In conclusion, the inspectors found that incidents were responded to by staff and reported for investigation, but some improvements were required with record keeping.

Judgment:
Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The provider has addressed two of the three action plans relating to risk identified at the designated centre.

The inspectors confirmed that the issues relating to ventilation in the cleaner's room on the first floor had been fully addressed and an electric fan was now in place. Measures to addressed damage to wall and ceiling of en-suite in room 35 had been taken, but

further external works were necessary to prevent recurrence according to the maintenance manager and these works were scheduled to take place in the spring. The visitor's room was clear from trailing electrical wires and no obvious hazards were visible.

The provider had engaged external consultancy and supports to provide an updated safety statement, and review the risk register. Neither document was available for inspection at the time of this unannounced inspection.

Risk management training was planned and due to take place for clinical nurse managers and identified staff in order to fully implement environmental audit and review. As outlined in this report and following a review of the newly implemented key performance indicator data collected, further work was required in order to establish staff competencies with the revised risk management plan and how to respond and address incidents, accidents and adverse outcomes and taking remedial action as required.

The inspectors found that the first clinical governance meeting had taken place on 3 February 2015 and were scheduled to take place on a two monthly basis. The minutes of this meeting did not sufficiently prioritise or risk assess actions or allocate responsibility or accountability for all of the actions identified for improvement or identify resources required.

The provider discussed the specifics of how an environmental audit would take place once a month and a designated staff member would do a hazard analysis in line with the policy. However, the health and safety co-ordinator has not yet commenced this role and will do so following training.

The inspectors discussed the findings of this major non-compliance with the provider nominee as the identified accountable person in the risk management policy, and the importance of identifying and maintaining an accurate risk register.

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

Findings:
The inspectors completed a full review of medication management at the centre and

were satisfied that each resident was largely protected by the designated centre's policies and procedures for medication management. Medication (unless prescribed for at mealtime) was not given during mealtimes, and these changes in practice had lead to a requirement to review times of administration which was discussed as part of the feedback to the provider.

The as required prescribed use of psychotropic medication was found to be documented and in line with best practice. The centre now collected data on the last day of each month regarding residents who were prescribed psychotropic medication on the day of data collection. The inspectors noted further to a review of medication administration charts that prescribed food supplements were not consistently signed for in line with the policy.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
The person in charge or her deputy had not notified the Authority about a resident admitted with pressure ulcers in line with the requirements of the regulations within the specified time frame. Systems were not in place to for the admitting nurse to identify and manage residents who are admitted with pressure ulcers as outlined in Outcome 11.

The inspectors acknowledge that the notification was received after the date of the inspection.

Judgment:
Non Compliant - Major

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The inspectors reviewed the four action plan responses in full during this inspection.

An additional health care assistant has now been allocated to work on the first floor during the day. The communication between staff had improved, and residents with identified requirements for supervision and assistance were provided with appropriate choices about meals, drinks and snacks. Residents were offered choices of drinks and snacks between meals. Inspectors observed residents being offered drinks and snacks between meals.

Two residents had sub cutaneous fluid therapy prescribed by the General Practitioner (GP), in progress and records were maintained of oral fluid intake also.

Documentation of residents nutritional assessment and care planning in place had improved, inclusive of new daily records which have been implemented since the time of the last inspection. However, the standard and quality of this documentation this inconsistently applied and gaps were evident in completion of records. The clinical nurse manager informed the inspectors that clear records were now in place to inform and guide staff on a daily basis about changes in residents.

Records were completed relating to residents who required drinks with a modified consistency and following any inputs from speech and language therapy, and dietetic review. Systems were also in place to prompt care plan review following these specialist inputs and also include in the handover system to staff.

On admission the residents' nutritional status was assessed and a nutritional care plan commenced, and referrals made for any specialist advise in a timely manner. At the end of the shift residents who required care plan review as a result of residents changing condition or have had their care plans updated were highlighted in a report for handover. However, if a nutritional care plan had not been created for a resident or assessment incomplete this update of documentation was not actioned by staff in line with best practice and regulatory requirements.

Further improvements were required relating to the existing systems in place regarding how each residents' food and fluid intake was documented by inputs into the electronic record keeping system. Systematic review was necessary for the identification of residents at risk of compromised nutritional status by nursing staff responsible for monitoring and evaluating care interventions as part of a daily and planned review of each resident. Gaps in documentation and examples were given at feedback to the provider nominee. For example, no nutritional assessment or care plan in place for resident admitted four days prior to the inspection who was noted on admission to

"need assistance with diet" and no weight recorded on admission, and no nutritional risk assessment completed. However, the resident was observed to be receiving the his meals with the appropriate level of assistance from staff.

Another example related to a review of residents fluid and food intake, the actual amount of fluid intake was not specified on the electronic record keeping system in use for residents whose fluid intake was identified as requiring close monitoring in an assessed care plan. Therefore the nursing staff reviewing oral intake could not base their judgments on the adequacy of inputs which may be inaccurate when reviewed on each nursing shift. This system of documentation and touch screen inputs was highlighted as part of the last inspection process.

The inspectors noted that a resident had been admitted for short term respite with pressure ulcers and this had not been notified to the Authority as outlined in Outcome 10 of this report. Systems and clinical oversights in place did not adequately support a process of staff on duty at the time of admission notifying as required by legislation. Nursing staff did not complete the full admission process, or complete all the required documentation risk assessments and care planning process in a timely manner.

Lack of nursing hours to undertake this documentation of clinical assessment was given as the reason in this case. An example of this was found on review of the records where the most recent resident comprehensive assessment form was updated at 04.37hrs on the day of the inspection for a resident. This assessment was found not to be completed in full by the assessing nurse or contain evidence of resident involvement at this time of the day.

Judgment:
Non Compliant - Major

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:
The inspectors were not satisfied that plans to address the dining space requirements and communal day space on the first floor had not been fully addressed by the provider

at the time of the inspection. No written plans or report had been received which would adequately address the requirements of Schedule 6 of the regulations.

The findings of this inspection confirmed good provision of dining space in the main dining room, which was bright and spacious. Residents confirmed they enjoyed eating their meals in this space. The provider had extended dining space in the assisted dining room beside the sun room, to include part of the existing activities room to accommodate more residents, who wish to come to dine in the dining room. Meal services are also provided by use of a hot trolley sent to the communal day spaces on each floor. The furnishings and seating in the communal day rooms are more suited to sitting rooms, and there had been no provision of appropriate dining tables and chairs to these areas.

The provider nominee informed the inspectors that plans were in place to re-organise the communal day space to meet the individual and collective needs of the residents. This included purchasing new furniture and consultation with residents and relatives about the proposed changes. 38 residents could be accommodated on the first floor, but day space was mainly to be found on the ground floor accessed by stairs or the passenger lift. The first floor had seating placed on corridors and one communal day dining space as described in the registration inspection report.

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

Findings:
The provider had partially addressed this non-compliance. Systems and clinical supervision of resident dining and drinks and fluids offered to residents had improved since the time of the last inspection. While there were policies and procedures in place, some gaps were evident in how the documentation was kept, and nutritional care plans were not in place for residents identified as requiring interventions as outlined in Outcome 11.

Two mealtimes were observed by the inspectors present, in the four areas where meals where served on both floors. The menus provided have been reviewed by a dietician

according to the person in charge and inspectors observed all foods attractively presented including those on modified diets. The organisation of mealtimes has improved in a number of ways; the standards and mechanism of supervision of residents who require any form of assistance with their meals was in place, and staff were aware of each residents' assessed requirements.

The nursing staff were now engaged supervising mealtimes and not in medication management during lunch and tea-time meal service, and they actively participated in supervising the four dining areas where residents ate their meals, and also provided appropriate supervision and staff for assisting residents who preferred to eat in their rooms.

The communal day space on each of the two floors was also utilised by residents for meals. However, the environment has not been fully reviewed to ensure the appropriate furniture and layout of rooms assessed. Residents with cognition difficulties or dementia were not receiving the appropriate cues to promote nutritional intake from an environmental perspective and this aspect requires review as part of the action plan outlined in Outcome 12 of this report.

While inspectors observed improvements since the time of the last inspection further staff training and guidance will to be necessary for staff when serving and assisting meals to promote person hood. For example, staff seen cutting meals up, and putting sauces on main meal for residents without asking if this was the option preferred by the resident and in line with their likes and dislikes. Drinks were served by staff in the dining room, and choices offered by staff.

Judgment:
Substantially Compliant

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:

This non-compliance has been partially addressed by the provider. Nursing staff had re-organised their working day and were supervising mealtimes instead of administering medication at these times. The inspectors acknowledge information received that a further permanent staff nurse would be returning from planned leave by the agreed timescale of 28 February 2014, and that additional care assistant hours had been put in place on the first floor.

Staffing rosters were found to be fully maintained and kept up to date with the names of the agency staff employed by the provider. However, the provider has not submitted a formal review of staff rostering and allocation as outlined in the response to the last inspection report within the agreed time frame.

Staff supervision arrangements were found to have improved since the time of the last inspection. For example, medication management and supervision of mealtimes. However, further improvements were necessary to fully implement the improvements and changes in work practices required to meet the requirements of the regulation. The provider stated that training was scheduled for identified staff in the following areas; risk management. clinical documentation, and cardio-pulmonary resuscitation. No overall review of staff competencies was evidenced by the provider to clearly identify and address staff training needs.

The number of qualified nursing staff was reduced due to planned leave, and temporary cover was being provided by using agency night staff and a relief staff nurse employed by the provider. The inspectors requested that staffing arrangements are reviewed overall, and particularly focusing on the use of agency staff on a permanent basis for provision of nursing care to the ground floor on the night shift.

Staff meetings took place and staff confirmed to inspectors that they attended a reflective de-briefing session based on a clinical incident which took place at the centre and found this very beneficial. The inspectors discussed with the provider the need to evaluate staff competency. The provider said that they have yet to implement any form of staff appraisal system.

Judgment:
Non Compliant - Moderate

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:

Leone Ewings
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[1]

Centre name:	St Gabriel's Nursing Home
Centre ID:	OSV-0000174
Date of inspection:	13/02/2015
Date of response:	10/04/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The current management systems were found to be ineffective leading to poor outcomes for residents.

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

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

monitored.

Please state the actions you have taken or are planning to take:
The Management and Directors of St. Gabriel's are committed to improving the management and governance of the nursing home and have identified measures for both the immediate and long term. Having reviewed the role of the current person in charge, the following actions have been agreed to address the need for effective management and governance in the centre:

With immediate effect:
We have appointed an experienced Provider Nominee for 1 year to undertake the role of Provider Nominee. We have submitted an NF38 to HIQA. The new Provider Nominee has commenced in this role since the 23rd March 2015. The Person in Charge has reverted back to her role as Person in Charge only. The Provider Nominee will be at the designated care centre for a minimum of one full day per week and as required. The Provider Nominee will be available to the Person in Charge when ever needed. The Provider Nominee will take responsibility for the following:

1. The development of a governance and management framework for the centre in collaboration with the Person in Charge.
2. Attending and directing each clinical governance meeting.
3. Overseeing the development of action plans from each meeting, which will have specific timeframes and identified persons responsible for each action.
4. Meeting with both the person in charge and provider nominee designate on a weekly basis (or more frequently as required). The Provider Nominee will monitor progress with current non-compliances in accordance with this action plan and monitor progress with any additional action plans developed from clinical governance meetings.
5. Ensure that designated care centre is in compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

A Provider Nominee Designate has taken up the post from 24th February 2015. An NF 31 has been sent to HIQA. This Provider Nominee Designate is currently receiving on the job training from the Provider Nominee and is also attending the centre with the current provider nominee and with the person in charge one day per week. It is anticipated that the Provider Nominee Designate will be put forward for approval as a Provider Nominee in February 2016.

The proposed structural changes at senior management level within the nursing home will ensure that the service provided is safe, appropriate, consistent and effectively monitored as required under Regulation 23(c).

We have commenced the process of recruiting an Assistant Director of Nursing for the centre. The ADON's role will be to assist the Person in Charge in her role, with a specific focus on Clinical Governance. The ADON will act as the Person in Charge in the absence of the DON. The recruitment of the ADON .commenced on 19th March 2015. It is anticipated that this will take a maximum of 4 months. Interviews have been arranged for 17th April 2015.

Proposed Timescale: 31/07/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The review of quality and safety did not adequately provide for the views or was made in consultation with residents and their representatives.

Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
There is currently an active bi-monthly residents meeting in place facilitated by an external advocate and attended by residents, their relatives, the Person in Charge and Activities Provider. The resident's requirements and views guide the provision of service in the Nursing Home. The first relatives meeting has been planned for 15th April 2015, facilitated by same independent advocate and also attended by the Activities Provider and Person in Charge (quarterly thereafter).

A resident and relative satisfaction survey questionnaire is being developed and will be disseminated for completion during the last week of April 2015. This questionnaire is based on the 18 outcomes so as to link with and be included in the annual review of quality of care and services. It also includes criteria to allow for quality of life to be surveyed.

We will carry out a separate quality of life survey for resident's with dementia using a recognised tool for measuring quality of life in residents with cognitive impairment and dementia. This will be carried out during the last week of May 2015.

Both of the above tools will be available for inspection.

Proposed Timescale: 31/05/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The lines of accountability in the organisation are not clearly defined, regarding specific roles, and detailed responsibility for all areas of care provision.

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:
A governance and management framework will be developed for the centre and include the following information:
• Roles and responsibilities of all grades of staff in the centre.
• Reporting relationships and reporting arrangements for all staff.
• The framework will reflect changes in roles and structures as outlined throughout this action plan.

Proposed Timescale: 17/04/2015

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:
The information about resident transfers and deaths was not easily retrievable when requested.

Action Required:
Under Regulation 19(2) you are required to: Make the directory established under regulation 19(1) available, when requested, to the Chief Inspector.

Please state the actions you have taken or are planning to take:
The information about residents' transfers and deaths was retrievable by the inspector but in some instances was incomplete. Appropriate staff have been instructed of the requirement to keep the register updated. The Person in Charge is keeping the register under review and to-date the register is fully compliant with regulation requirements.

Proposed Timescale: 10/04/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The records of the investigation where a resident suffers abuse or harm, did not include records of all relevant methodology and details of the results of the investigation and actions taken in line with Schedule 3 record keeping requirements.

Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
The Person in Charge acknowledges that while the investigation took place; that records of all relevant methodology and details of the results of the investigation and actions taken were not complete in one particular incident.

A standard template for completion and recording of investigations into allegations of abuse will be developed. The template will guide the investigation process and ensure that all documentation required is identified.

Proposed Timescale: 10/04/2015

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 updated risk register and safety statement were not available for inspection.

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:
Both of the above documents will be available for inspection on the 31st March 2015.
To ensure that there is a robust health and safety and risk management system for the centre, we have commenced the following programme of activities:
• Risk management training has been provided for staff on both the 19th and 26th February 2015.
• Two days mentoring have been arranged for the health and safety co-ordinator to include conducting an environmental health and safety audit, completing risk assessments for hazards and risks identified and maintenance of the risk register. The mentoring is being carried out by an external health and safety professional.
• The health and safety co-ordinator carried out an environmental health and safety audit on the 18th March 2015, in preparation for the mentoring programme.
• As part of the mentoring programme, the external consultant will review the audit carried out, the updated health and safety statement and the risk register with the health and safety co-ordinator and provider nominee.
• The two days mentoring are the 23rd and 27th March 2015.
• An environmental health and safety audit will be carried out on a quarterly basis.

Proposed Timescale: 31/03/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Environmental hazard identification and documented assessment of risk has not commenced at the designated centre by the health and safety co-ordinator in line with risk management policy.

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:
Both of the above documents will be available for inspection on the 31st March 2015. To ensure that there is a robust health and safety and risk management system for the centre, we have commenced the following programme of activities:
• Risk management training has been provided for staff on both the 19th and 26th February 2015.
• Two days mentoring have been arranged for the health and safety co-ordinator to include conducting an environmental health and safety audit, completing risk assessments for hazards and risks identified and maintenance of the risk register. The mentoring is being carried out by an external health and safety professional.
• The health and safety co-ordinator carried out an environmental health and safety audit on the 18th March 2015, in preparation for the mentoring programme.
• As part of the mentoring programme, the external consultant will review the audit carried out, the updated health and safety statement and the risk register with the health and safety co-ordinator and provider nominee.
• The two days mentoring are the 23rd and 27th March 2015.
• An environmental health and safety audit will be carried out on a quarterly basis.

Proposed Timescale: 30th March 2015 (monthly thereafter)

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:
The clinical governance group does not sufficiently risk rate or action areas identified for improvement in a robust manner.

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

Please state the actions you have taken or are planning to take:
A standardised format for clinical governance meetings will be implemented from the next scheduled meeting on the 14th April 2015.

A clinical governance action plan will be developed and used as a live document to be reviewed at each meeting by the group so as to monitor progress of both non-compliances and improvement plans.
The action plan will prioritise actions and detail timeframes for action as well as the person(s) responsible for each action and any resources required.

The template for minutes of clinical governance meetings will be altered so as to identify priority actions and allocation of responsibilities for all of the actions identified and resources required.

Areas identified as requiring improvement actions at each meeting will be added to the clinical governance action plan.
A review of any new hazards or risks will be included in the clinical governance meetings.
A review of all incidents that have occurred since the previous meeting will be carried out as part of the format of clinical governance meetings, including identification of learning and actions to disseminate that learning.

Where new risks have been identified as a result of trending and analysis of quality and safety data at each meeting, these will be risk assessed, prioritised and added to the risk register. Any action planning required as a result of the risk assessments will be added to the clinical governance action plan.

The minutes will reflect all of the activities undertaken at each meeting and include any action plans developed.
In future and up to the appointment of a new provider nominee designate in 2016, clinical governance meetings will be attended by a member of the board of directors.

Clinical governance meetings, development of action plans and review of the clinical governance action plan will be supervised by an approved provider nominee as outlined in Outcome 2.

Progress of action plans, with specific reference to those that are prioritised for action will be monitored by this provider nominee at each clinical governance meeting and on a weekly basis with the person in charge.
This will be effective from 14th April 2015, when the next Clinical Governance Meeting is scheduled; and on-going thereafter).

Proposed Timescale: Commence 14th April 2015 and ongoing.

Proposed Timescale: 14/04/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training in the revised risk management policy has not been provided for relevant staff working at the designated 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:
Risk Management training has been provided for the Person in Charge/Provider Nominee, all Nursing Staff, the Health & Safety Co-ordinator and the Health & Safety representative on 19th & 26th February 2015. The Provider Nominee Designate has also attended a 2 day training course in Health & Safety Training in Healthcare on 9th March 2015.

Proposed Timescale: 10/04/2015

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:
Prescribed food supplements were not consistently signed for by nursing staff.

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:
All Nursing Staff have been instructed to consistently sign for all medications including food supplements. The medication audit tool has been updated to include the need to check that food supplements have been signed so that this can be monitored during medication audits.

Proposed Timescale: 10/04/2015

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident admitted to the designated centre with pressure ulcers had not been reported as required by regulations.

Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
As part of the risk management training and reflective practice sessions that were delivered during January and February, nursing staff were informed of the procedure that must be followed where any incident involving a resident occurs. This included the need for informing the clinical nurse manager and person in charge as well as record keeping requirements.

As a reminder to all Nursing staff, a list of all notifiable incidents is now prominently displayed at each Nurse's station, along with the actions required i.e. informing Person In Charge of notifiable event.

A new handover system has been implemented on each floor. All new incidents of pressure ulcers must be recorded on the shift handover form. In order to monitor compliance with this system, from the 30th March 2015, the person in charge and the CNM on duty will each attend one of the morning handovers so as that they are kept up to date with any changes in residents' conditions and any events / incidents that have occurred.

They will also ensure that the handover form is completed as required so as to ensure that all events and incidents involving residents are recorded.

Following the handover, the CNM and person in charge will provide direction to staff regarding the safety priorities for the shift, with specific reference to those residents requiring additional monitoring. Both the CNM and person in charge will meet following the handover to report back to each other.

A midday handover will take place each day on each of the floors and the CNM and person in charge will also attend these, so as to be kept informed of any changes or new events / incidents affecting residents.

The CNM on duty will check with each nurse on a formal basis in the afternoon and prior to the evening handover to monitor any changes in residents' care and / or condition; check on any new events or incidents that have occurred and to monitor the completion of assessments and care plans for new admissions and those requiring update because of changes in their condition. The CNM will also check that any additional record keeping requirements and follow up actions related to incidents have been completed.

Proposed Timescale: 30/03/2015 and ongoing.

Proposed Timescale: 30/03/2015

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:
Detailed nutritional care plans based on assessment were not found to be in place for all residents 48 hours following admission.

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

Please state the actions you have taken or are planning to take:
At both the reflective practice sessions and the risk management study days, emphasis was placed on the risks associated with poor record keeping practices related to assessment and care planning. Nursing staff were also instructed that they must complete assessments and commence care plans for residents who are admitted during their shift. Nurses were also instructed that each resident must have a care plan in place for nutrition as well as the other ADLs.

In order to further emphasise the importance of timely and comprehensive record keeping, an admission protocol will be developed to include:
• Specific timeframes for completion of admission documentation, including assessments and care plans for all activities of living.

• A place for each nurse to sign following completion of each assessment and care plan and other required documentation for each resident.

As previously outlined, the CNM on duty will be responsible for checking on a formal basis during the afternoon and prior to the night time handover that all required admission assessments and care plans are completed.

Care plan audits are scheduled as part of the audit programme on a three monthly basis to continue to monitor assessment and care planning practices.

Proposed Timescale: 30/03/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of care staff inputs on touch screen not fully reviewed by nursing staff in a consistently robust and meaningful way to ensure best outcomes for the resident record sample reviewed.

Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Previous action plan:
A standard protocol will be developed for nursing staff on completion of daily records. This will include:
• The need to update all relevant assessment and care planning documentation for any resident whose care and / or condition has changed during their shift.
• The need to review all records completed by healthcare assistants for an individual resident prior to completing that resident's daily records and to follow up on any area of concern noted in these records.

Proposed Timescale: 30/03/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The residents' food and fluid intake is not subject to adequate robust clinical review in line with nutritional care plans in place to reflect individual assessments.

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

Please state the actions you have taken or are planning to take:
The CNM on duty will check with each nurse on a formal basis in the afternoon and prior to the evening handover to monitor any changes in residents' care and / or condition; check on any new events or incidents that have occurred and to monitor the completion of assessments and care plans for new admissions and those requiring update because of changes in their condition. The CNM will also check that any additional record keeping requirements and follow up actions related to incidents have been completed.

Dietician's will continue to be available as required and from April 15 Dietician will also be visiting the centre on an 8 week cycle to review residents.

As previously stated a standard protocol will be developed for nursing staff on completion of daily records.

Proposed Timescale: 15/04/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Resident comprehensive assessment forms are being completed out of hours by nursing staff and not completed in line with best practice and no documented evidence of consultation with the resident, or where appropriate the resident's family.

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

Please state the actions you have taken or are planning to take:
A comprehensive pre-admission assessment is completed and documented by the Person in Charge or Deputy. The nurse collects information from this and other referral documentation to inform the assessments. The initial post admission assessment is commenced by the Staff Nurse on Duty on the day of admission. Nurses now meet with the residents to verify information received and to complete the assessment and care planning process with them during normal hours and at a time acceptable to the resident and/ or representative (where available) within the 48 hour period.

Evidence of the residents' involvement will be available through documentation of their agreement with the assessment and care plan or where they are unable, the views and observations of their representative as required by An Bord Altranais Guidance.

Three monthly care plan audits include the criterion that there is evidence of the involvement of the resident and / or representative in the care plan.

Also, the residents and relatives satisfaction survey includes questions related to the involvement of the resident/representative in the assessment and care planning process and their opinion on the provision of information to facilitate this process.

This will facilitate monitoring compliance with same.

Proposed Timescale: 31/05/2015

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Dining space was found to be inadequate to meet all residents' needs.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
As acknowledged by the inspector the main and assisted dining rooms meet the needs of the residents who choose to dine there. There are a small number of residents who choose to dine in the communal areas on both floors. To provide them with a dining experience enjoyed by residents who attend the dining rooms plans to increase the size of both ground and first floor sitting rooms have been submitted to the city council for approval. A planning application was lodged with Fingal County Council on 1st March 2015. It is expected that planning permission will be granted by 1st June 2015. It is planned that building will commence immediately thereafter. (See plans attached)

Once the building works have been completed appropriate furnishing will be provided to ensure that residents will have an equally pleasurable experience regardless of where they choose to dine. In the interim we will source more appropriate dining tables for residents who choose to dine in the sitting room.

Proposed Timescale: 31/08/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Access to day space on first floor of designated centre was limited.

Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
As acknowledged by the inspector the main and assisted dining rooms meet the needs of the residents who choose to dine there. There are a small number of residents who choose to dine in the communal areas on both floors. To provide them with a dining experience enjoyed by residents who attend the dining rooms plans to increase the size of both ground and first floor sitting rooms have been submitted to the city council for approval. A planning application was lodged with Fingal County Council on 1st March 2015. It is expected that planning permission will be granted by 1st June 2015. It is planned that building will commence immediately thereafter. (See plans attached)

Once the building works have been completed appropriate furnishing will be provided to ensure that residents will have an equally pleasurable experience regardless of where they choose to dine. In the interim we will source more appropriate dining tables for residents who choose to dine in the sitting room.

Proposed Timescale: 31/08/2015

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:
Residents were not seen to be offered choices consistently at mealtimes, to promote personhood.

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:
Nutritional assessments have identified residents who require assistance to cut up meals. In order to minimise any psychological discomfort to the resident staff have been reminded to perform this action prior to serving the resident. As staff believe they know and understand residents preferences, we have reminded staff to allow residents reaffirm their individual preferences at mealtimes.

Documentation is readily available in each dining area that highlights individual residents who require full assistance. In order to promote independence the documentation also highlights residents who may require some level assistance while dining.

Proposed Timescale: 10/04/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Nursing staff complement on the roster were not fully in line with the numbers submitted as part of the registration process and stated in the statement of purpose for the 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:
2 staff nurses who were on short term leave have returned to full time duty. An additional nurse also commenced employment on 16th March 2015. This reduces the requirement for agency cover on a permanent basis. A further staff nurse has been recruited who has been in the final stages of ABA registration for some time. We have been informed that the ABA Pin will be issued in the next 2 weeks. This person is available to start immediately on receipt of registration. This will bring the nursing complement in line with the numbers submitted as part of the registration process and stated in the statement of purpose for the centre.

We have reviewed our present staff nurse complement and are satisfied that the daily allocation of nursing hours is sufficient to meet the needs of the numbers of residents, their dependency levels and the layout of the building.

Proposed Timescale: 30/04/2015

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff supervision measures are not fully established in order to safely meet the ongoing assessed and changing needs of each resident.

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:
As above, permanent Nursing hours have been restored so this should improve supervision of care assistants.

As previously outlined, the role of the CNM and person in charge in directing staff following handover and attending midday handovers will improve staff supervision. Staff supervision will also be strengthened by the CNM following up on a formal basis with Nurses regarding assessment care planning.

Proposed Timescale: 30/03/2015

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing arrangements and whole time equivalent requirements inclusive of a review of the use of temporary nursing staff is required to ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, 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:
As per workforce (1).

2 staff nurses who were on short term leave have returned to full time duty. An additional nurse also commenced employment on 16th March 2015. This reduces the requirement for agency cover on a permanent basis. A further staff nurse has been recruited who has been in the final stages of ABA registration for some time. We have been informed that the ABA Pin will be issued in the next 2 weeks. This person is available to start immediately on receipt of registration. This will bring the nursing complement in line with the numbers submitted as part of the registration process and stated in the statement of purpose for the centre.

We have reviewed our present staff nurse complement and are satisfied that the daily allocation of nursing hours is sufficient to meet the needs of the numbers of residents, their dependency levels and the layout of the building.

Proposed Timescale: 30/03/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff complement employed have not had a review and a training needs analysis completed by the person in charge.

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 preliminary training needs analysis will be carried out by the person in charge, proposed provider nominee, the human resources manager. This will be updated as required from the findings of performance appraisals.

Performance appraisals for nursing staff will be conducted by the Person in Charge. They will commence by 15th May 2015. It is envisaged that these performance appraisals will be completed by 30th September 2015.

Performance appraisals for non-nursing staff will be completed by the relevant head of department. This will commence in May 2015.

All mandatory training for all staff within the centre is complete and up to date.
Additional training completed to-date covered
- Reflective Practice (following serious incident)
- Risk Management Training
- CPR
- Modified Diets & Fluids

Additional training scheduled for 2015
- Clinical Audit for Nursing Staff
- Recognising & Responding to Clinical Deterioration in Residents.
- Privacy and Dignity.

Where individual performance issues have been raised, personalised training plans have been put in place to address performance standards.

Proposed Timescale: 30th September 2015 & 31st December 2015

Proposed Timescale: 31/12/2015