

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Castletownbere Community Hospital
Centre ID:	OSV-0000601
Centre address:	Castletownbere, Cork.
Telephone number:	027 70004
Email address:	Cathy.Sheehan@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Patrick Ryan
Lead inspector:	Mary O'Mahony
Support inspector(s):	Vincent Kearns; Aoife Fleming; Maria Scally
Type of inspection	Announced
Number of residents on the date of inspection:	29
Number of vacancies on the date of inspection:	2

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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 February 2015 09:30	10 February 2015 18:00
11 February 2015 09:30	11 February 2015 19:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
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 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

Castletownbere Community Hospital was established as a residential centre in 1932. The building was single storey and it was originally a former coastguard station. It was now managed by the Health Service Executive (HSE) and provided long stay, respite, community support and palliative care for the local community. There were 29 residents accommodated there at the time of inspection, 18 of whom had been diagnosed with dementia. There were two vacant beds, according to the person in charge. The centre also catered for a resident with disabilities. The main entrance opened into a bright but very narrow, conservatory type, sitting room facing out to a view of the harbour. There was a reception office in the hallway and the corridor led to the bedrooms, toilets and showers, chapel, nurses station, treatment room,

kitchen and staff facilities.

Residents were accommodated in three four-bedded rooms, two three bedded rooms, four two-bedded rooms, and five single rooms. En suite wash hand basins, toilets and showers were available in all rooms with the exception of one single room. There was an assisted toilet with wash hand basin and shower located directly across the hall from this room.

The external grounds were well maintained with ample car parking facilities. Exit doors had an electronic alarm system for residents with cognitive impairment, assessed as being at risk of wandering from the premises. A number of Health Service Executive (HSE) services, for example, a day centre, operated from the same site as the community hospital but were managed independently.

A number of improvements were required to comply with 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. These improvements included the following: safeguarding and safety: health and safety and risk management: medication management: notification of incidents: documentation: complaints procedure: nutrition and staffing.

In particular there continued to be significant failings as regards compliance with the Regulations on premises which were highlighted during previous inspections, the most recent of which was undertaken in April 2014. The initial action plan for premises upgrade received by the Authority following this inspection was rejected as there were no plans submitted, there was no evidence that funding had been procured and there was no feasible timeline set out for completion. The second action was also rejected for similar reasons.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose was viewed by inspectors. It was up to date, regularly reviewed and described the service and facilities provided in the centre. It contained the information required in Schedule 1 of the Regulations and also outlined the aims, objectives and ethos of the centre. Staff, spoken with by inspectors, were familiar with the statement of purpose.

Judgment:

Compliant

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 were sufficient resources in place to ensure the effective delivery of the service.

The person in charge was available throughout the inspection. The person in charge was supported by an experienced clinical nurse manager (CNM). There were clear lines of

authority and accountability. There were daily care handover meetings and all grades of staff were included in these meetings. However, the systems to manage, audit and document risk were not robust and these will be addressed under outcome 8: Health and Safety and Risk Management.

Inspectors saw evidence of staff meetings and observed that issues were addressed accordingly. There was evidence of consultation with residents and relatives in the minutes of residents' meetings.

Inspectors examined the results of residents' and relatives' pre-inspection questionnaires for this inspection. They were praiseworthy of the staff and the service.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

The Resident's Guide was seen by inspectors and it was available to all residents. Each resident has a written contract agreed on admission which set out the services to be provided in the centre and the fees payable by the residents. However, the cost of additional services (e.g. hairdresser costs) which were to be incurred by the resident was not set out clearly in the contract as required by the Regulations.

Judgment:

Substantially Compliant

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:

The person in charge worked full-time and was a registered nurse with 28 years experience as a nurse in the centre. 14 of these years were spent in a management role. She was currently employed in the centre as the acting person in charge.

Inspectors noted that residents were familiar with the person in charge. Staff who spoke with inspectors were clear about who to report to and were aware of the management structure in the centre. The acting clinical nurse manager 2 (CNM2) deputised in the absence of the person in charge and was seen to be also fully involved in the management of the centre.

Based on records viewed by inspectors, there was evidence that the person in charge had a commitment to her own continued professional development. There was also evidence that the person in charge held frequent staff meetings. Residents, relatives and staff informed inspectors that the person in charge was present in the centre on weekdays. Inspectors formed the view that the person in charge was a suitably experienced nurse with authority and accountability for the provision of the service.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Records required under the Regulations were maintained in the centre. The records were securely stored and staff with whom inspectors spoke said that residents had access to their files, if required. Inspectors viewed a selection of residents' care plans. Each care plan outlined the social and medical needs of the resident. There was evidence of input from, and assessments by, allied health professionals, where necessary. Inspectors found evidence that the plans were individualised. There were policies which were updated and reviewed when required and these included the policies specified in Schedule 5 of the Regulations. Staff demonstrated an understanding of these and inspectors viewed a signature sheet for staff to sign when the policies were read. However, inspectors noted that not all the policies were implemented for example,

the procedures to be followed in the event of an allegation of abuse, the policy on the use of PRN (when required) medications and the policy on complaints. Some policies were not updated within the three year time frame required by the Regulation for example the policy on the use of syringe drivers. This was particularly relevant as a resident was requiring the use of a syringe driver at the time of inspection. There was no policy on staff training and on staff induction and the policy on communication was out of date. The risk management policy did not contain the controls in place for the risks specified under Regulation 26 (c) (i) to (v). This was addressed under outcome 8: Health and safety and risk management. Not all policies were centre specific for example, the medication management policy.

The centre was adequately insured against injury to residents according to the insurance certificate viewed by inspectors. Fire safety records were seen and were found to have met the requirements of the Regulations as regards, training, testing and maintenance of the system. Inspectors viewed a sample of staff files and found that they were generally maintained in good order. However, not all files contained a curriculum vitae (CV) and evidence of Garda vetting as well as a record of gaps in employment for some staff. This will be addressed under outcome 18: Staffing. There was no signature sheet available for staff on the medication management sheet to enable inspectors to check compliance with the requirements of Schedule 3 section 4 (b). There was a policy for volunteers in the centre and guidelines were set out for the parameters of the role and the responsibilities attached. The staff roster was viewed and inspectors saw that it correlated with the staffing levels which the person in charge had outlined. Inspectors viewed the directory of residents which contained all the details required under legislation. However, there were no records available to indicate that discussions were held with residents and their representatives about the decision or not to receive CPR (Cardio-Pulmonary-Resuscitation). As the centre had a defibrillator this was significant and in addition, inspectors observed that there was no policy in the centre on the use of a defibrillator even though there was a policy available on DNAR (do not attempt resuscitation).

Inspectors were shown a complaints and incident log. Most complaints were documented and they were investigated. However, inspectors noted that not all complaints were recorded. In addition, inspectors viewed a sample of complaints recorded which indicated that allegations, which could be construed as allegations of abuse, had been investigated under the complaints policy and had not followed the procedures set out in the centre's policy on the prevention of elder abuse. Furthermore, the Authority had not been notified of these allegations, within the specified timeframe, as set out in legislation. Nevertheless, the required documentation was forwarded to the Authority following the inspection. These failings were addressed under outcome 7: Safeguarding and safety, outcome 10: Notifications and outcome 13: Complaints.

Training records were maintained in the centre however, these were not up to date and did not indicate that all appropriate training had been provided to staff. This will be addressed under outcome 18: Staffing: The centre utilised a daily flow chart for recording care given to residents. However, inspectors noted that this was not correctly completed for a resident who was very ill at the time of inspection. In this particular situation nursing notes recorded on a supporting pink 'communication' sheet did not correlate with the information in the daily flow sheet which inspectors found was

incorrect. Inspectors observed that fluid balance and food recording charts were not maintained for residents who had infections and were confined to bed. The daily flow sheet system of recording health conditions and medical care was discussed with the person in charge along with the discrepancies which were found by inspectors. This flow sheet system of recording did not comply with the requirement of Regulation 21, Schedule 3, 4 (c) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 or with the guidelines as set out in An Bord Altranais agus Cnaimhseachais na hEireann "Recording Clinical Practice Guidance for Nurses and Midwives" 2002.

Judgment:

Non Compliant - Major

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There had been no period when the person in charge was absent from the designated centre in excess of 28 days. The person in charge informed inspectors that the acting CNM2 was the identified person to take charge in the event that the person in charge was absent from the centre. Inspectors found that the acting CNM2 was a registered nurse who had the appropriate qualifications and management experience to take on this role in the absence of the person in charge. The provider was aware of her responsibility to notify the Authority of any such absence.

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:

The person in charge stated that staff were made aware, on a regular basis, of the policy on the prevention of elder abuse. She attended staff handover meetings to ensure that she was informed of any issues regarding residents' care and welfare. She showed inspectors the daily notes she made at these morning meetings. Staff were able to confirm their understanding of the types of elder abuse. They explained how they would support a resident in this situation. Inspectors viewed the policy for responding to allegations of adult abuse. This policy was comprehensive and provided details in relation to the actions required by staff when responding to an allegation to elder abuse. However, inspectors noted in the complaints log that there were five incidents recorded which contained details that were potentially allegations of abuse. These potential allegations of abuse were not investigated as such but were recorded and investigated as complaints. This was not in line with the guidelines in the centre's own policy or the 'Trust in Care' (HSE 2005) document which required a GP review or psychological assessment of the resident. This also required that the person in charge would speak to the resident and consult with another manager, that the event would be notified to the Authority within three days of its occurrence and the names of the resident, the staff member or the relative would be recorded. This process had not been undertaken in the centre in response to allegations. In addition, staff training records indicated that all staff had not received updated mandatory training in the prevention and response to elder abuse. Some staff with whom inspectors spoke did not demonstrate sufficient knowledge of the internal processes for recognising and reporting alleged abusive interactions. In the area of management of allegations of elder abuse inspectors found that there were multi-factorial failings and these were discussed with the person in charge. These factors included, inadequate training, poor recording of incidents, inadequate management of the allegations and no notifications to the Authority. These failings were captured under outcomes 10: Notifications, outcome 13: Complaints and outcome 18: Staffing.

The centre had a policy on behaviour that challenges. However, all staff had not been afforded the specific training outlined in the policy to enable them to respond to and manage this behaviour safely. According to the records seen, a family member of a resident complained that the resident had been placed into an empty single room for most of the day because of calling out. However, there was no care plan in place for this resident or any professional guidelines indicating that this solution was recommended in this situation. In addition, there was no evidence that other strategies had been tried or that there had been a discussion with the resident's relatives about this. It was also noted by inspectors that a resident's nursing notes indicated that he was "given sedation due to aggression". There was no indication in the care plan seen by inspectors if this medication was effective.

Inspectors reviewed the measures that were in place to safeguard residents' money and noted that receipts were obtained and where possible residents' or their representatives' signature had been recorded. Transactions on residents' accounts were clear and transparent. Residents' valuables were in safekeeping and accurate records of these were seen by inspectors. The administrators informed inspectors that the centre carried out frequent internal and external financial audits.

Judgment:

Non Compliant - Major

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 a comprehensive emergency plan in place which detailed the actions to be taken by staff in the event of emergency situation. It specified the arrangements for the evacuation of residents and identified an external location for the temporary placement of residents. The emergency plan was found to meet the requirements of legislation. The fire prevention policy was viewed by inspectors and was found to be detailed and centre-specific. There were signs placed prominently around the centre to alert staff and residents to the procedure to follow in the event of a fire. The emergency lighting was checked and serviced at regular intervals and inspectors viewed these records. Documentation and evidence was also seen which indicated that the fire extinguishers were maintained and serviced as required. Fire training was provided to staff on a number of dates in 2013 and 2014. Fire evacuation drills were undertaken on a yearly basis. However, Regulation calls for these to be held at regular intervals and inspectors formed the view that this was not a suitable interval, when the layout of the premises and the dependency of residents were taken into account. Staff spoken with by inspectors were aware of the procedure to be followed in the event of a fire. However, not all staff spoken with by inspectors had received updated fire training. The fire alarm and the fire doors were checked regularly and these records were checked by inspectors.

Inspectors viewed the record of accidents and incidents. The records indicated that the issues were investigated. However, where some of these incidents involved cuts and tears to residents these had not been notified to the Authority where the resident may have required medical treatment. This will be addressed under outcome 10:

Notifications. The centre had a risk register which was updated when new risks were identified and inspectors were shown the health and safety statement for the centre. This identified the responsibilities of staff in managing risks and promoting health and safety in the centre. The risk management policy was reviewed in 2012 but this did not outline the controls for the risks specified under regulation 26 (1). The person in charge said that the centre had a health and safety committee which met every few months. The centre had the services of a health and safety consultant and the person in charge said that regular audits were carried out. Hand sanitisers and sinks were present at the entrance to the building, on the corridors and in the staff and resident areas. Inspectors saw that gloves were stored safely. Hoists, wheelchairs, weighing scales, electric beds

and mattresses were serviced on a regular basis and these records were seen by inspectors. The centre had an outside smoking area. There were risk assessments noted in the files of residents who smoked and staff were also obliged to use the outside smoking area as the centre was a non-smoking area.

Clinical risk assessments were undertaken for the residents, including falls risk assessment, dependency levels, nutrition, skin integrity, continence and moving and handling. However inspectors observed that residents did not have individual risk assessments for absconson risks and behaviour that challenges, in their files. In addition not all risks in the centre had been identified and risk assessed. Inspectors observed that oxygen was stored in the treatment room and the storage of this had not been risk assessed. Inspectors found that a fan heater had been left running in one shower area and as a consequence this room was very hot, Inspectors saw that there had previously been an incident where the smoke alarm had been triggered by heat and steam in a shower room. Controls had not been put in place to prevent fan heaters being left on and the risk of these overheating had not been identified. In one twin bedroom there was only one privacy curtain and the risk to the second resident's privacy and dignity need had not been assessed. This also happened to be one of the rooms through which an amount of daily 'traffic' passed. This will be addressed also under outcome 12: Premises.

Inspectors observed staff generally abiding by best practice in infection control with regular hand-washing and the appropriate use of personal protective equipment such as gloves and aprons. However, water in the hair-dresser's sink in one section was very hot when checked and this was tested by inspectors and found to be above 51' C. This was addressed and reset at the time of inspection. However, this had not been risk assessed. Inspectors observed a number of issues that potentially compromised infection control and presented a high risk of cross contamination including; the hairdressing sink was located next to a toilet, laundry trolleys and cleaning trollies were stored in a dirty sluice room. Inspectors noted that a urinal was stored on the window sill of an en suite. None of the above issues had risk assessments in place identifying the hazards and setting out controls to mitigate the risks involved.

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 operational policies relating to the ordering, prescribing, storing and

administration of medicines to residents. However, the policy was not centre specific. The practice of checking, dispensing and recording of drugs administered, including controlled drugs, was in line with current legislation. Controlled drugs were checked by inspectors and the recording of these drugs was found to be correct. Photographic identification for residents was present on the medication sheets.

However, medications were not identifiable on the prescription sheet and there was no signature sheet with the prescription sheet or medication trolley to identify the initials of staff administering medication.

Medication management audits were conducted and the findings were disseminated to staff involved in medication administration. Medication reviews were conducted regularly by the GP and documented in the medical notes. However, residents were not offered a choice of GP or pharmacist as required by the regulations. Staff reported that there was an attentive GP service to the centre. The pharmacist provided support and education on medication management and staff reported that the pharmacist was responsive and attentive to the needs of the centre. The centre had a policy on medication errors which outlined the process for recording and learning from medication errors.

Inspectors observed that in some cases the maximum dose of PRN (as required) medication was not stated. The policy for PRN medication prescribing, administration and review was not centre-specific. This was addressed under outcome five: Documentation. There was no system for documenting the effect of PRN medications. This was relevant because one resident was given sedative medication on two occasions on day one of the inspection and inspectors failed to find documentation as to why this was necessary and documentation to indicate the effect of the medication. There was no behaviour plan in his file to outline why his behaviour was treated with sedation and no indication of what alternatives were tried, if any.

Nursing staff, spoken with by inspectors, demonstrated an understanding of the An Bord Altranais agus Cnaimhseachais na hEireann Guidelines for Nurses on Medication Management. However, not having a signature sheet for staff to enable identification of the initials used in the medication administration sheet did not comply with best practice guidelines for recording clinical practice published in 2002. This was addressed under outcome 5: Documentation.

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:

There were incident and accident forms maintained for both residents and staff in the centre. The person in charge had notified the Authority of some incidents in line with the requirements under Regulation 31 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 within the required timeframes. However, there were a number of incidents recorded where residents had received lacerations and skin tears which had not been notified to the Authority as well as incidents of chemical or environmental restraint. In addition, between May 2014 and July 2014, there had been three incidents of an unexplained absence of a resident from the designated centre and a further incident where the same resident was found trying to exit the centre through an open window. None of these incidents had been notified to the Authority as required by the Regulations. In one incident the resident had travelled a distance from the centre before his absence was noticed. Furthermore, inspectors could not find any evidence that an individual risk assessment in relation to this individual had taken place. There was no evidence that an appropriate care plan had been drawn up as a result of any risk identified. Controls had not been improved and observations had not been commenced to minimise the risks of this happening again. As the centre was located near to the harbour this risk was discussed at length with the person in charge to highlight the gravity of the risk identified by inspectors. Furthermore, the policy in the centre on dealing with missing persons which was dated April 2014 did not include the necessity to notify the Authority of such incidents.

There had also been allegations of abuse of residents brought to the attention of the person in charge over the previous few years, for example on 20/01/2011. These had been investigated as complaints and they had not been notified to the Authority within three days of the receipt of the allegation as per regulatory requirements. One of these allegations had come to the notice of the Authority in recent months through an unsolicited receipt of information prior to the inspection. In addition, allegations of misconduct against staff members had not been notified to the Authority. Furthermore, an incident of environmental restraint and chemical restraint had not been notified as per the legislation. This was outlined in more detail under outcome seven: Safeguarding and safety. These were discussed with the person in charge and the CNM 2. The complaints book was not a bound log and for this reason the records were difficult to retrieve. For example one complaint dated 20/01/2011 stated that a resident alleged that she was being abused by staff. Readers were referred to 'sheet 11' which was not available and which the person in charge could not locate for inspectors. Complaints will be addressed in more detail under outcome 13: Complaints.

Guidance in the centre's policy on the prevention of abuse stated that "The person in charge shall ensure that notice is given to the chief inspector without delay of:

- 1) any occurrence of any allegation suspected or confirmed of abuse and
- 2) any allegation of misconduct by the provider or any person who works in the centre.

Judgment:

Non Compliant - Major

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

Residents were provided with the services of a GP on admission however, Regulation 6 (2) (a) required that the resident shall be offered a "medical practitioner chosen by or acceptable to that resident" and inspectors noted that this choice was not facilitated by the centre. Residents received a full review of all their medical care and their medication was updated as necessary. Residents with whom inspectors spoke expressed satisfaction with the medical care provided to them. The person in charge outlined the assessment process for the residents coming to the centre. Residents were not assessed prior to admission but this was carried out on admission. A physiotherapist was employed by the HSE to offer services to residents. A podiatry service was also available and residents had access to an optician, a dentist and an occupational therapist if required. These services were availed of in house and on an external basis. Dietary advice and speech and language therapy (SALT) were provided by allied health professionals and from a nutritional company, who also offered training to staff. Inspectors viewed the training records of staff and saw that staff had training in nutrition, dysphagia (difficulty in swallowing) and food hygiene.

Inspectors viewed a number of residents' care plans which outlined residents' needs and choices. Inspectors observed that care was seen to be delivered to residents in accordance with their care plan. However, the information in the care plans lacked sufficient detail and there were discrepancies noted by inspectors. For example, a daily flow sheet was used to record daily care. There was a pink communication sheet in use for those residents who required a narrative note. However, use of the narrative note was not consistent. Inspectors noted that the information in the flow sheet did not correlate with the information in the pink communication sheet for a very ill resident. The information in the flow sheet indicated that the resident had no pain while the communication sheet indicated that the resident had received pain relief for moderate pain. The flow sheet also indicated that a resident had eaten three full meals the previous day. A relative informed inspectors that she could not get the resident to take a drink the previous day and in fact had been offered a syringe to help with giving fluids. This practice was unsafe as the resident had a chest infection and was recumbent in bed and drowsy. Inspectors noted that there were no fluid balance and food intake records maintained for this resident and for others who were ill, confined to bed and in some

cases on antibiotics. This was addressed under outcome five: Documentation. These inaccuracies and omissions were pointed out to the person in charge who was asked to re-evaluate the type of documentation in use, in light of the requirement to maintain detailed nursing and nutrition care plans. The tick box, numerical format of the flow sheet did not comply with section 4 (c) of Schedule 3 of the Regulations and the requirements of An Bord Altranais agus Cnaimhseachais na hEireann, Recording Clinical Practice Guidelines for Nurses and Midwives, 2002 section 7.4. These required that a narrative note was maintained of the person's health and condition and treatment given, completed on a daily basis, in line with professional guidelines.

The care plans were reviewed on a four monthly basis as required by the Regulations and there was documented evidence of residents' involvement in parts of the care planning process. However, inspectors observed that there were no individual plans of care or risk assessments for residents who exhibited behaviours that challenge, including for those residents who were at risk of absconding. Inspectors noted that the care plan of one resident who had been admitted from a disability sector did not have adequate transfer information in his new file particularly as regards his behaviour needs. Staff informed inspectors that the information received had been summarised, however the resident had complex needs for which adequate care plans had not been drawn up, in line with information from his disability service. This person who was now a full time resident in the centre was noticed by inspectors to have very little personal space in his bedroom and no privacy. Staff informed inspectors that he used the bathroom to get dressed in the mornings and evenings. However, inspectors found that this arrangement was not suitable as the bathroom was observed to be very cold.

Residents had access to their personal file if required. A section of the personal file was stored at the end of residents' beds. The person in charge was asked to assess this against the risk to residents' privacy considering that residents' life history documentation was contained in the files in multi occupancy rooms. Guidelines from the national policy on restraint were followed in the implementation of restraint when necessary and inspectors observed that consent forms had been signed by residents and their representatives. There was evidence that staff were liaising with the relevant medical teams where required for residents. Residents were also facilitated to attend various consultant or other medical appointments. Residents requiring end of life care had access to specialist palliative services and these personnel attended to residents during the inspection. Inspectors saw evidence in a resident's file that medications were reviewed and pain relief adjusted. However, end of life care plans were not specific or detailed for example, there was no evidence of position changes and oral care plans for these residents.

There were some opportunities for residents to pursue healthy lifestyle choices and recreational activities. There was a wholesome and varied diet available. There was ongoing monitoring of each resident's health status and staff regularly checked residents' weight, blood pressure and blood tests. There was an activity programme in place for residents. Inspectors saw this programme displayed on the notice board in the centre. Some activities happened on the day of inspection such as music and art work. However, inspectors noted that only three or four residents attended some of the activities as the sitting room was small and a large number of residents spent the day sitting in their bedrooms. Nevertheless, in some bedrooms there were small tables

where residents were seen to sit enjoying their tea.

Judgment:

Non Compliant - Moderate

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:

None of the actions in relation to premises, generated from the most recent inspections of 13 September 2013 and April 2014 had been addressed. Actions pertinent to the premises had been issued in all previous inspections carried out by the Authority. These actions were as follows:

- 1) inadequate physical design and layout to meet the needs of residents
- 2) provide adequate sitting space separate to residents' private accommodation
- 3) provide adequate recreational space separate to residents' private accommodation
- 4) provide suitable communal space for social, cultural and religious activities

The main door to the centre opened into the conservatory/sitting room. Visitors accessed the centre through this room. The room was also used for the following:

- as a reception area
- as a dining room
- as an activities room.

There was little space for wheelchair-bound residents or residents using high-dependency chairs, to manoeuvre within the sitting room. Inspectors noted that there were large chairs stored along one side of this narrow room. There was also a large TV and one table which served as the dining table for all residents in the centre. This table seated four residents. The lack of space in this room had a severe impact on the choice available to residents as to their dining space. It also impacted negatively on the privacy and dignity of residents requiring help with their meals or wishing to sit in private in the sitting area, as everybody who came into the centre used this door as an entrance and as an exit.

As observed on previous inspections, adequate dining space for residents, separate to the residents' private accommodation, was not provided. There was one

mentioned, dining table and four dining chairs for the total complement of the 31 residents potentially accommodated in the centre. Inspectors noted that one or two residents had lunch at the dining table and some residents, accommodated in high-dependency mobile chairs or wheel chairs, also had their lunch in this room. This arrangement did not make the dining experience enjoyable or homely. The remaining residents had their meals at their bedside, in bed or at small tables in some of the bedrooms.

The following premises observations did not comply with the Regulations and did not provide a suitable living environment for residents:

- the day room could not accommodate all the residents residing in the centre
- residents, accommodated in mobile chairs could not dine at the dining table as the table was not large enough
- the day room was also used as a store for extra chairs and wheelchairs.
- suitable spacious communal sitting space separate to the residents' private accommodation was not provided for residents, apart from a small alcove in the corridor which did not afford privacy as it was central to all passing traffic
- recreational space separate to the residents' private accommodation was not provided.
- the current location of the reception/administrative office did not allow staff visual access to the main entrance door.

Bedroom accommodation as discussed under previous outcomes had serious shortcomings also for example, in one twin bedroom there was only one curtain which meant that the other resident was not afforded privacy and dignity, did not have a private space to sit by his bed and did not have space for a chair by his bed. This also happened to be one of the two two-bedded rooms through which an amount of daily 'traffic' passed, including commodes, cleaning trollies, staff toilet, and residents attending the hairdresser, thereby presenting a further risk to the privacy and dignity of residents in the those bedrooms as well as residents passing in and out to get their hair done. Inspectors observed that a further consequence of the lack of space in the centre meant that there was no place for the hairdressing sink apart from being located next to a toilet. In addition the lack of space also meant that laundry trollies and cleaning trollies were stored in sluice rooms as well as commodes, laundry trollies and resident care trollies.

Bedroom 1 was a two bedded room with an en suite shower and toilet. There was not enough room for bedroom chairs by the beds for visitors to visit in private.

Bedroom 2 was similar to bedroom 1

Bedroom 3 was a four bedded room. There were a number of personal items on display in the room but there was not enough room for bedside chairs for each resident.

Bedroom 4 was a four bedded room, there was limited space in this room and as a consequence one wardrobe was not adjacent to the resident's bed but was stored in the corner of the room. There was no room for a bedside chair next to all beds in this room. The overhead hoist in this room was not working at the time of inspection. There were three residents in this room who exhibited behaviours that challenge. There was a fourth resident in the room who was a new respite resident. The person in charge said that for example, one resident called out at night and had to be got up most nights at about 03.30am. This was disturbing to other residents who would wake then also. Inspectors noted that the TVs in the rooms were positioned very high for the needs of

residents' due to the lack of space in the rooms. Residents sitting on wheelchairs by their beds had to have their beds moved out of position to be able to sit next to their bed.

Bedroom 5 was a two bedded room through which staff had to access the sluice and cleaning room as mentioned above and one resident did not have a curtain to cordon off his bed. There was only one bedside locker in this room. There was no screen inside the double access door to this room. There was no possibility of privacy in this room and it was not suitable for two residents as it was a 'corridor' in essence. There was no lockable storage space in this room. There was no space for chairs and there was not sufficient space for staff to work at both sides of the bed.

Bedroom 6 was a single room with an en suite toilet and shower. It was in use for palliative care at the time of inspection.

Bedroom 7 was a four bedded room. Due to lack of space there was room for only two bedside chairs.

-There was a double door opening into a four-bedded room and one bed was directly in front of these doors. The screens surrounding this bed did not meet in the middle.

Inspectors were told that there was a portable screen in use for these eventualities. However, inspectors saw that this screen was stored in an outside storage area in inaccessible place.

Bedroom 8 was a three bedded female room. There was adequate space in this room for chairs and wardrobes and it also had an en suite toilet and shower area. There was room for a small round table and chair in this room.

Room 9 was a two bedded room and similar to room 5 it was an access 'corridor type' room into a toilet, sluice and cleaning room area. There was an amount of trollies, commodes and laundry trollies stored in the back sluice room because of a lack of other appropriate storage space.

Room 10 was a single room with an en suite toilet and shower room.

Room 11 was a three bedded room with adequate space.

Room 12 room 13 and room 14 were single rooms with en suite toilet and shower rooms, the shower room for room 12 was accessed across the corridor.

There was no assisted bath in the centre and this restricted the residents' choice as regards washing facilities. The centre had a small family room and a third sluice room which was used for storage as above. There was a clinic room and a staff room which were securely with a keypad lock. The centre had a chapel and staff offices also. There was an outdoor storage area for smoking.

Inspectors noted that there was a complaint in the complaints log that a resident was very noisy in a communal bedroom and a further complaint that another resident kept turning off the TV when a resident was watching it.

The person in charge acknowledged to inspectors that the centre had serious premises challenges as regards space, room for private visits, room for storage and bedside chairs, a proper dining and art room and the impact on the residents' privacy and dignity of the small two bedded rooms. The person in charge was informed that there was continued non compliance in the centre and that the Authority now required a costed, specific, realistic, time bound plan with available funding, to comply with Regulations.

Judgment:

Non Compliant - Major

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The centre had policies and procedures for the management of complaints. The process for making a complaint was displayed in a prominent position in the centre. There was a nominated person to deal with complaints and there was a complaints log maintained in the centre. However, inspectors noted that there was a lack of consistency in the management of complaints. There was no structure to the complaints log and there was not sufficient detail maintained on aspects of complaints such as the names of the people involved. In addition, there was no process in place to implement learning from complaints and inspectors noted that the satisfaction or not of complainants was not always recorded. A record of whether or not a complaint was referred to a third party was not maintained. Prior to the inspection the Authority had received a complaint as part of an unsolicited receipt of information. This was discussed with the person in charge. Records of this investigation were seen by inspectors.

Some complaints of alleged elder abuse were recorded as complaints and not notified to the Authority as already addressed under outcome 10: Notifications. A complaint in a resident's care plan was not recorded in the complaints log. This involved the use of environmental restraint in an effort to manage a resident's behaviour.

What was common to a large number of complaints was:

- the GP had not been asked to review the resident where applicable
- where an investigation had been instigated into a complaint it had not been completed in all cases
- appropriate allied health professionals had not been alerted for advice and the outcome of the complaint was not recorded
- not all relevant documents could be found for inspectors such as a particular page referred to as 'page 11' in one complaint.
- notes were not kept in an organised and easily accessible manner and there were notes kept in different books
- notifications were not made to HIQA where appropriate.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There is a written policy in place for end-of-life care which staff are familiar with. Inspectors noted that residents received end-of-life care which respected their right to autonomy and dignity. Private rooms were made available for residents at end-of-life. There was evidence that residents had access to palliative care services. The centre had a syringe driver available on site (a mechanical pump used to administer medications) used for symptom management. Staff were aware of the policy on the use of a syringe driver, however, the policy was out of date and had not been recently renewed. This was addressed under outcome 5: Documentation

All religious and cultural practices were facilitated. There was a weekly religious service in the chapel in the centre. Family and friends were facilitated to visit and be with residents at end-of-life and a family room with tea/coffee/snacks was provided. Open visiting was facilitated at this time.

Inspectors reviewed care plans of residents at end-of-life. There was not sufficient evidence in care plans that all residents had a choice as to place of death as this information had not been recorded. A relative spoken with by inspectors said she did not feel comfortable talking with staff about her family member's wishes as it was not a subject that had been brought up with her. Nevertheless, the religious denomination of residents was documented, as well as discussion with family on some occasions. Inspectors noted that staff were very knowledgeable and provided appropriate care for residents at end-of-life. However, care plans did not fully document and direct the care being delivered for example mouth-care and pressure relieving care.

Staff spoke with inspectors about the support they received from the GP who visited the centre on a daily basis and also of the attention received from the specialist palliative team. Inspectors noted that the centre had information on bereavement support available.

Judgment:

Substantially Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The centre had up to date policies on food and nutrition. The provision of training for staff on matters pertaining to food and nutrition was ongoing. Staff training records indicated that staff had attended training in food and nutrition for the older person, eating drinking & swallowing workshops and food safety and hazard analysis and critical control points (HACCP) training. Inspectors observed mealtimes including breakfast, dinner and tea time lunch. Residents had the option of having their breakfast served in bed, or sitting out at their bedside. Snacks, hot and cold drinks including juices and fresh drinking water were readily available throughout the day. Inspectors noted that staff levels were adequate to meet the needs of residents during mealtimes. Residents having their meals were appropriately assisted and received their meal in a timely manner. The lack of dining space was discussed under outcome 12: Premises. Assistive cutlery required for a resident with reduced dexterity was available.

Resident meetings were held three-monthly. Overall the residents were complementary of the food on offer in the centre. Inspectors met with staff on duty in the kitchen. These staff were informed about the menu on offer, residents' food choices and preferences, residents experiencing weight loss/gain and particular dietary requirements. A two-weekly menu rotation was in place. An up to date folder with dietetic advice and SALT plans to guide staff, was available in the kitchen. However, inspectors noted that a resident who had been assessed as requiring texture C diet had been getting a texture B diet, as the staff member informed inspectors that she had not noticed that this had been changed. There was evidence that choice was available to residents for breakfast, lunch and evening tea. Residents confirmed that a staff member came around daily informing them what was on the menu. Residents stated that they had a choice and could ask for anything they wanted. There was evidence that the kitchen staff regularly sought feedback from the residents with regard to the meals served.

A number of residents were on prescribed nutritional supplements and some residents received their meals in a modified consistency. A sample of medication administration charts reviewed evidenced that nutritional supplements prescribed by the general practitioner for residents were administered accordingly. Breakfast was served to residents from 07:45 hrs onwards. Lunch was served at 11:50 hrs. The privacy and

dignity of residents who availed of assistance with their meals was considerably compromised as a result of the design and layout of the day room. This was discussed in more detail under outcome 12: premises.

Residents with whom inspectors spoke said that they enjoyed the food in the centre. Staff were observed assisting residents, particularly residents with a cognitive impairment, in a sensitive and discreet manner. Meal times were unhurried and staff were observed using the mealtimes as an opportunity to communicate with residents. However, one resident who was capable of eating independently if the food was easy to manage was given a boiled egg in its shell, for tea. This meant that he had to be assisted to eat his meal and this reduced his autonomy. This was addressed under outcome 16: residents' rights dignity and consultation. The menu of the day was displayed in a prominent place in the day room. Evening tea was served at 17:00 hrs. Inspectors were informed by staff that the residents had access to dietetic services and speech and language therapy services. Kitchen staff confirmed that both services consulted with them, The clinical nurse manager (CNM) stated that it was difficult to access occupational therapy services.

There was evidence that residents had a malnutrition universal screening tool (MUST) assessment on admission, four monthly or when required. Staff, spoken with by inspectors, were familiar with how to assess and use the tool. Dental oral care assessments were regularly carried out for residents. Residents' weights were recorded three monthly or more often and it was evident that the documentation of a weight loss/gain prompted an intervention. There was evidence that residents' clinical risk assessments informed residents' care planning. Residents with diabetes had a care plan guiding their care. Inspectors noted information in residents' care plans regarding the recording of blood sugar levels. Residents had individual glucometers to check their blood sugar in the centre.

Judgment:

Non Compliant - Major

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents were consulted with how the centre was planned and run. Inspectors were

shown minutes of residents' meetings and copies of relatives' surveys. Resident and relatives' questionnaires were filled in for the Authority prior to inspection. These were mainly praiseworthy of the centre and of the staff. Residents had access to independent advocacy services and inspectors saw evidence of information on this service displayed in the centre. The centre had a copy of the health service executive (HSE) guide to multicultural practices at end of life. The person in charge informed inspectors that residents were facilitated to vote if they wanted to.

However, there was evidence that practices in the centre were led by routine and resources of the centre. Meals times appeared to be early to facilitate staff breaks and residents were back in their bedrooms early, after tea, as there were less staff available for the night shift. Staff informed inspectors that a certain number of residents had to be in bed to facilitate the night routine, as the staff nurse would be busy administering medications, following the night report. In addition, inspectors saw a list of designated visiting hours displayed in the centre. This restriction on visiting hours was not in compliance with the requirements of the Regulations. Furthermore, staff informed inspectors that the lack of an activity staff member meant that activities were not always available. Inspectors formed the view that the facilities for recreation and activities were inadequate for the following reasons: there was a lack of communal space to organise a communal activity session, activities on the day of inspection had a limited attendance and relatives spoken with by inspectors said that activities were not regularly held in the centre.

There were signs on doors asking staff and visitors to knock before entering bedrooms. However, inspectors saw staff entering rooms without knocking and on one occasion going to a resident's wardrobe without asking the resident's permission first. Inspectors noted that residents' meals were not always prepared in a manner that encouraged independent eating. An example of this was a resident who had vision impairment who informed inspectors that he could not eat his meat because it was not cut up small enough. When it was cut up to suit his needs he was able to finish his meal independently. This was also an issue, as mentioned under outcome 11, for another resident, who required his food to be prepared in a way that enabled him to maintain his independence. As regards maintaining a resident's dignity, inspectors noted that there was a complaint in the complaint log that one resident was sent out from the centre, to a relative's wedding, without her dentures in. There was no indication in the log as to the outcome of this complaint;

Inspectors observed that language used in documentation was infantilising to these older adults. For example residents were referred to as 'patients', bedrails were called 'cot sides' and words like 'aggressive', 'demanding' and 'caustic' were used to describe residents' behaviour. These words were noted by inspectors during the inspection, when talking to staff and when reading residents care plans. The approach was further verified by relatives who informed inspectors that there were occasions when residents were spoken to like 'children', particularly any resident who presented with behaviours that challenge. Relatives also informed inspectors that they felt that care in the centre was not as good at the weekends when the management team was not on duty. Responses in some questionnaires also stated this. Inspectors spoke with the person in charge about these comments. She said that there was a senior nurse on duty at the weekend and she would ensure that that person was identifiable to visitors and

residents at weekends as the senior person on duty.

A number of significant rights and dignity issues were addressed under outcome 12: premises, also.

Judgment:

Non Compliant - Major

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors observed that an inventory of residents' personal property was maintained in residents' care plans. There was adequate and accessible storage space for residents' personal possessions. However, not all residents had a lockable storage space for personal possessions as required by Schedule 6, 3 (h) of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Staff informed inspectors that residents' laundry was outsourced to an external contractor and that clothing was labelled. There were no outstanding issues regarding missing items of clothing.

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):

No actions were required from the previous inspection.

Findings:

The person in charge informed inspectors that there were appropriate staffing levels and skill mix available in the centre to meet the assessed needs of residents. There were sufficient staff for the size and layout of the centre. Staff had access to education and training. However, not all staff had undertaken mandatory training such as fire training and elder abuse prevention. One staff member did not have training in manual handling since 2010. In addition, some staff did not have training in elder abuse. There was no policy on staff training and staff induction in the centre.

There was no curriculum vitae (CV) or Garda vetting documentation available in one staff file of the sample checked by inspectors. All staff did not have training in managing behaviours that challenge and de-escalation techniques, which was appropriate to their role in the centre. Volunteers in the centre had their roles and responsibilities set out in writing. Inspectors saw that the staff rota matched the staff on duty during the inspection. There was a nurse on duty at all times in the centre. Staff with whom inspectors spoke were aware of the Health Act 2007 and the Regulations and Standards for older adult care.

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:

Mary O'Mahony
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Castletownbere Community Hospital
Centre ID:	OSV-0000601
Date of inspection:	10/02/2015
Date of response:	15/05/2015

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 03: Information for residents

Theme:

Governance, Leadership and Management

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

The residents' contracts did not include details of the cost of any other service which the resident might choose to avail of, but which was not included in the Nursing Homes Support Scheme, or which the resident was not entitled to under any other health entitlement.

Action Required:

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

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

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

Hairdressing – Contract of Care now contains reference to Hairdressing Fees

Proposed Timescale: 15/04/2015

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:

Not all policies were prepared, adopted and implemented as required under Schedule 5. For example:

- the policies on elder abuse and complaints were not adopted and implemented
- the policy on staff training and staff recruitment were not available in the centre
- the risk management policy was not set out in line with the Regulations
- the policy on PRN (when necessary) medications was not implemented for example the maximum dose of PRN medications to be administered in 24 hrs was not stated which did not comply with An Bord Altranais agus Cnaimhseachais Na hEireann Guidelines for Nurses on Medication management.

Action Required:

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

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

Policy on Elder Abuse and Complaints adopted and implemented. – 15th April 2015

Policy on Staff Training and Recruitment now available. – 15th April 2015

Risk Management Policy under review – 31st July 2015

Policy on PRN Medications is implemented. – Medical and Nursing Staff now complying with Policy – 15th 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:

Not all policies in the centre were reviewed at intervals not exceeding 3 years and, where necessary were not updated in accordance with best practice. Not all policies related to the centre in question- for example the medication management policy was not centre specific.

Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

All Policies are currently being reviewed & updated.

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

Not all the records required under schedule 2, 3 and 4 were maintained in the centre for example:

- a full employment history of each staff member
- a vetting disclosure for each staff member
- a record of residents decision to receive or not to receive certain treatment such as a record of a decision to receive cardio-pulmonary-resuscitation (CPR)

Action Required:

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

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

Full employment History of each staff member – 31st May 2015
Garda vetting has been obtained for all Staff – 20th April 2015
Discussion to take place with the medical officer, a record of resident's decision to receive CPR will be documented in the resident's notes – 30th June 2015

Proposed Timescale: 30/06/2015

Theme:

Governance, Leadership and Management

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

Not all records of the residents' medical treatment and health condition were maintained in an accurate and complete manner.

For example,

- inspectors noted that information on the daily flow sheet of a very ill resident was not accurate and nursing notes recorded on a supporting pink 'communication' sheet did not correlate.
- fluid balance and food record sheets were not maintained for residents who had

infections and were confined to bed.

-there was no signature sheet available for staff on the medication management sheet to enable inspectors to check compliance with the requirements of Schedule 3 section 4 (b) of the Regulations.

Action Required:

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

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

Fluid balance and Food Record sheets are now maintained for Residents who have infections and are confined to bed.

Signature sheets for Medication Management completed and available as per requirements Schedule 3 Section 4

Proposed Timescale: 13/04/2015

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:

Not all staff had up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

All staff to receive training on 'responding and managing behaviour that is challenging'.

Proposed Timescale: 30/09/2015

Theme:

Safe care and support

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

Not all staff were trained in or had updated knowledge in the detection, prevention and response to abuse.

Action Required:

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

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

New members of staff have now completed Elder Abuse training – 26th March 2015
Continuing Education on Elder Abuse for all staff

Proposed Timescale: 26/03/2015 and ongoing

Theme:

Safe care and support

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

All incidents and allegations of abuse were not investigated in line with the centre's policy but were dealt with under the complaints policy.

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:

All incidents and allegations of Abuse will now be investigated in line with the Centre's Policy.

Proposed Timescale: 30/04/2015

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:

Not all hazards had been identified and assessed throughout the designated centre.

Examples of these were:

- residents did not have individual risk assessments for absconsion risks and challenging behaviour in their files
- oxygen was stored in the treatment room and the storage of this had not been risk assessed
- controls had not been put in place to prevent fan heaters being left on and the risk of these overheating had not been identified
- in one twin bedroom there was only one privacy curtain and the risk to the resident's privacy and dignity need had not been assessed.
- there was an amount of daily 'traffic' passing through two of the twin bedded rooms, including the movement of commodes, cleaning trollies, staff toilet, and residents having their hair done thereby presenting a further risk to the privacy and dignity of residents in the twin bedded rooms.
- water in the hair-dresser's sink was found to be above 51' C

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:

While a generic Risk Assessment is included in the Risk Register, this risk will now be included in the Resident's Individual Care Plan.

Following the Nursing Report each morning Safety Pause is undertaken – "What Patient Safety Issues do we need to be aware of today".

Rick Assessment of Oxygen storage in Treatment Room is now completed.

Fan Heater switches identified and labelled, turned off after use and staff urged to be vigilant re same.

Twin Bedded Room – Independent Healthcare Services carried out a survey of all screens(08/05/2015). Awaiting report and quotation.

Storage of Commodes, Cleaning trollies and use of Hairdressing sink to be addressed with new the new build.

Water Temperature in Hairdressing sink has now been addressed - 16th February 2015.

Proposed Timescale: 31/07/2015

Theme:

Safe care and support

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

The risk management policy did not set out the measures and actions in place to control abuse as one of the risks specified in Regulation 26.

Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

Measures and actions to control abuse will now be included in the Risk Management Policy.

Proposed Timescale: 30/06/2015

Theme:

Safe care and support

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

The risk management policy did not include the measures and actions in place to control the unexplained absence of any resident.

Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

Measures and actions will be included in the Risk Management Policy to control the unexplained absence of any resident.

Proposed Timescale: 30/06/2015

Theme:

Safe care and support

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

The risk management policy did not set out the measures and actions in place to control accidental injury to residents, visitors or staff.

Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Risk Management Policy now to include measures and actions to control Accidental injury to residents, visitors or staff.

Proposed Timescale: 31/07/2015

Theme:

Safe care and support

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

The risk management policy did not set out the measures and actions in place to control aggression and violence.

Action Required:

Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

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

Risk Management Policy will include measures and actions to control aggression and violence.

Proposed Timescale: 31/07/2015

Theme:

Safe care and support

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

The risk management policy did not set out the measures and actions in place to control self-harm.

Action Required:

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

Risk Management Policy will include measures and actions to control self-harm.

Proposed Timescale: 31/07/2015

Theme:

Safe care and support

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

Infection procedures were not consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were not implemented by staff in the centre:

Examples of this were

- the hairdressing sink was located next to the toilet
- residents' daily care trollies, laundry trollies and commodes were stored in sluice rooms where there was a bedpan washer and a sluicing sink
- inspectors noted that a urinal was stored on the window sill of an en suite

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:

Hairdressing Sink will be addressed in New Building
Resident's Daily Care Trollies are now stored in Linen Room – 20th April 2015
Storage of Laundry Trollies and Commodes will be addressed in the new build.
All staff informed of correct procedure re Urinal storage – 20th April 2015

Proposed Timescale: 30/04/2017

Theme:

Safe care and support

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

Fire drills were not held at suitable intervals

Action Required:

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

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

2nd Fire Training and Fire Evacuation Drills in the process of being organised for 2015

Proposed Timescale: Training Days 25/05/2015 and 04/06/2015

Theme:

Safe care and support

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

Not all staff in the centre had received fire training and fire drill training.

Action Required:

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

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

2nd Fire Training and Fire Evacuation Drills in the process of being organised for 2015.
Training Days 25th May 2015 and 4th June 2015

Proposed Timescale: 04/06/2015

Outcome 09: Medication Management

Theme:

Safe care and support

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

The centre did not provide residents with a choice of pharmacist as required by Regulation 29 (1)

Action Required:

Under Regulation 29(1) you are required to: Make available to the resident a pharmacist of the resident's choice or who is acceptable to the resident.

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

Residents have the choice of availing of another pharmacist, at their own expense.

Proposed Timescale: 31/05/2015

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:

Three day notifications are not being made in line with the requirements of the Regulations.

Examples of this were:

- allegations of abuse
- allegations of misconduct of staff
- incidents of absconsion

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:

All Notifications to HIQA will now comply with Regulations

Proposed Timescale: 08/04/2015

Theme:

Safe care and support

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

Not all incidents required to be notified to the Authority on a quarterly basis were notified.

Examples of this were:

- incidents of restraint such as chemical and environmental restraint.
- incidents of falls resulting in head lacerations or substantial skin tears

Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

All Notifications to HIQA will be submitted as per Regulations.

Proposed Timescale: 08/04/2015

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:

Not all care plans were individualised, reviewed and revised where necessary after consultation with the resident concerned and where appropriate that resident's family:

Some examples of this were,

- no individual care plans and risk assessments drawn up for residents who exhibited behaviours that challenge to reflect their changing needs
- no individual care plans and risk assessments for residents who were at risk of absconding or who had absconded to reflect the current risk.
- no end of life care plan for those who needs were changing daily
- no mouth care plans for residents at end of life stage
- no fluid and food intake chart for bedridden residents some of whom were on antibiotics to reflect the changing needs of residents.
- no detailed care plan for a special needs resident

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:

All Care Plans will be individualised, reviewed daily and will be revised 3 monthly.

Proposed Timescale: 15/04/2015

Theme:

Effective care and support

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

The documentation in use did not support the provision of a high standard of evidence based nursing care in line with professional guidelines issue by an Bord Altranais agus Cnaimhseachais na hEireann.

Examples of this were:

- inaccuracies in documentation between information on the flow sheet and on the pink communication sheet
- resident's pain inaccurately recorded
- no record of position changes for residents confined to bed

Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with

professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Nurses are now completing Flow Sheets and Communication Sheets contemporaneously.

Position changes for Resident confined to bed documented under Skin Integrity – 6B in Daily Flow Sheet.

All evidence based Nursing Care recorded and will comply with the professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Proposed Timescale: 31/05/2015

Theme:

Effective care and support

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

The centre did not provide residents with a choice of general practitioner as required by the Regulations.

Action Required:

Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

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

All residents have the option of using another GP in the locality, at their own expense.

Proposed Timescale: 08/04/2015

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:

The premises was not appropriate to the number and needs of the residents of that centre.

- the design and layout of the multi occupancy bedrooms meant that residents' privacy and dignity were seriously compromised
- there was no space for residents to sit on a comfortable chair by their bed or to have a visitor visit in private.
- not all residents had a lockable space
- lack of space in the centre meant that clean and dirty trollies were stored side by side in the dirty sluice room
- two two-bedded rooms in the centre were being utilised as thoroughfares for the passage of commodes, cleaning trollies, hairdressing and staff toilet. There was no screen in front of the door to this room. The bathroom off this room, five, was very cold.

- not all residents had a screen around their beds, not all screens met in the middle particularly in the 4 bedded room where one bed was directly in front of the double entrance door to the room.
- a portable screen which inspectors were told was used to replace screens was seen by inspectors stored in an outside storage area in a position where it was inaccessible
- residents TVs were positioned too high in the bedrooms for comfortable viewing.
- residents sitting on wheelchairs by their beds had to have the beds moved to make room for the wheelchairs to be placed next to their bed.
- residents had no choice to sit at the dining table for meals if that was their choice
- residents had no private area to sit with visitors other than their bedrooms
- resident had no recreational area where they could sit as a group for activities.
- The narrow sitting room area was also used for the storage of chairs in the evening

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

New Lockers being ordered – 31st July 2015
 Clean Trolley's now being stored in the Linen Room – 20th April 2015
 Blinds ordered for Panel on Door - 30th June 2015
 Bathroom Room 5 – Window opening monitored to avoid draughts.
 2 Portable Screens now in the premises. Survey conducted on existing screens by Independent Healthcare Services to ensure privacy and dignity of residents. Awaiting report.
 Maintenance Department to review Height of Residents TV's in Bedrooms - 31st May 2015
 Remaining issues will be addressed in the new build.

Proposed Timescale: 31/07/2015

Theme:

Effective care and support

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

The premises did not conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre in the following manner:

- 1) Inadequate physical design and layout to meet the needs of residents
- 2) it did not provide adequate sitting space separate to residents' private accommodation
- 3) the centre failed to provide adequate recreational space separate to residents' private accommodation
- 4) the centre did not provide suitable communal space for social, cultural and religious activities

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:

A design team has been appointed and plans will be completed by June 2015.

Planning permission will then be applied for, and provided there are no objections, it is anticipated planning will be granted by September 2015.

A tendering process will begin to appoint a suitable construction company, and this process is expected to be completed by January 2016.

We then expect construction to commence in Castletownbere Community Hospital, subject to the appropriate statutory approval and funding for same, by January 2016.

It is expected that the building works will be completed by April 2017.

Costings for the proposed works cannot be provided, until the tender is confirmed & complete.

Proposed Timescale: 30/04/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

A record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied was not maintained in the centre.

Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

All complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied will be logged.

Proposed Timescale: 08/04/2015

Theme:

Person-centred care and support

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

There were no records maintained in the centre to indicate whether complainants were notified of the outcome of their complaint and details of the appeals process if not satisfied.

Action Required:

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

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

Complainants will be notified of the outcome of their complaint.

Proposed Timescale: 08/04/2015

Theme:

Person-centred care and support

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

There was no documentation available for inspectors to view which would indicate if any measures required for improvement in response to a complaint had been put in place in the centre.

Action Required:

Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

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

All documents now record measures required to show improvement.

Proposed Timescale: 20/04/2015

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

Documentation was not available to inspectors which indicated that appropriate care and comfort of a resident approaching end of life, which addressed the physical needs of the resident concerned, was carried out. Examples of this were lack of mouth-care plans, no documentation indicating position change and no food and fluid intake charts.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

End of Life Care now to include Mouth Care and Food and Fluid intake charts.
Documentation indicating position change in Daily Flow Sheet.

Proposed Timescale: 30/06/2015

Theme:

Person-centred care and support

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

Regulation 13 (1) (d) requiring that a resident's preference as to location of place of death be facilitated was not complied with as there was no documentation in residents' files to indicate that this discussion had taken place, with the resident or a representative.

Action Required:

Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

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

All preferences now documented in Care Plan and facilitated in so far as reasonably practicable.

Proposed Timescale: 31/05/2015

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:

A resident who had been prescribed a texture C diet by a member of the dietetic team was being provided with a texture B diet.

Action Required:

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

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

Speech & Language Therapist to conduct in-house training re diet textures.
All staff to be vigilant with resident's diet textures.

Proposed Timescale: 30/06/2015

Outcome 16: Residents' Rights, Dignity and Consultation**Theme:**

Person-centred care and support

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

The centre did not provide opportunities for residents to participate in activities in accordance with their interests and capacities and for occupation during the day. Throughout the two days of inspection residents were not observed to be engaged in meaningful activities and were seen to spend long stretches of time alone in their rooms, without staff engagement, apart from the time spent on care issues.

Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

Activities will be reviewed in conjunction with resident's ability to participate.

Proposed Timescale: 31/08/2015

Theme:

Person-centred care and support

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

Lack of space and privacy issues in the centre meant that among other privacy issues, residents were not afforded space to sit in the sitting room in private, to sit by their beds in private and in some cases did not to have a screen to pull around their bed.

Action Required:

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

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

Every effort is made to ensure that each residents privacy is respected, new screens will be purchased and the issues regarding the lack of space will be addressed in the new build.

Proposed Timescale: 30/04/2017 - new screens - Contractor on site 08/05/2015. Survey conducted. Awaiting report.

Theme:

Person-centred care and support

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

Inspectors noticed that there was a list of visiting times displayed in the centre. This

was not in compliance with legislation which states that in so far as is reasonably practicable, visits to a resident are not restricted unless there is a very specific reason for this or if a resident requests such a restriction.

Action Required:

Under Regulation 11(2)(a) you are required to: Ensure that in so far as is reasonably practicable, visits to a resident are not restricted, unless such a visit would, in the opinion of the person in charge, pose a risk to the resident concerned or to another resident, or the resident concerned has requested the restriction of visits.

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

Visiting times are no longer restricted, unless there is a very specific reason for this, or if a resident requests such a restriction.

Proposed Timescale: 08/04/2015

Theme:

Person-centred care and support

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

The centre did not afford suitable communal or private visiting spaces outside of the resident's bedroom, to residents and their visitors.

Action Required:

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

A private area is made available for a resident to receive a visitor, if required. A room specific for this purpose will be addressed in the new build. Ongoing & April 2017.

Proposed Timescale: 30/04/2017

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

Not all residents had access to a lockable or secure storage space for personal possessions such as valuable items or money as required under Schedule 6 part 1 section 3 (h) of the Regulations on Premises.

Action Required:

Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

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

New lockers with keys to be ordered.

Proposed Timescale: 31/07/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Not all staff had training appropriate to their role for example manual handling and managing challenging behaviour.

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:

Access to appropriate training organised for staff.

Proposed Timescale: 30/09/2015