<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Athlunkard House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000729</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Athlunkard, Westbury, Clare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>061 345 150</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@athlunkardnh.com">info@athlunkardnh.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Killure Bridge Nursing Home Partnership</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Patricia McCarthy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Costelloe</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Aoife Fleming</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>97</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>7</td>
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</table>
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a change in person in charge. This monitoring inspection was un-announced and took place over 1 day(s).

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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>21 April 2015 10:00</td>
<td>21 April 2015 18:00</td>
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</table>

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
<th>Outcome 02: Governance and Management</th>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
<th>Outcome 07: Safeguarding and Safety</th>
<th>Outcome 08: Health and Safety and Risk Management</th>
<th>Outcome 09: Medication Management</th>
<th>Outcome 10: Notification of Incidents</th>
<th>Outcome 11: Health and Social Care Needs</th>
<th>Outcome 12: Safe and Suitable Premises</th>
<th>Outcome 13: Complaints procedures</th>
<th>Outcome 18: Suitable Staffing</th>
</tr>
</thead>
</table>

**Summary of findings from this inspection**

This report sets out the findings of a follow up unannounced inspection that took place on one day. The inspection focused on the areas where improvements were required as highlighted in the action plan of the previous inspection report of 20 January 2015.

There were 19 actions to be addressed from the previous inspection. On this inspection the inspectors noted that 7 actions had been addressed, 7 actions were partially addressed and the remaining 5 actions relating to governance and management, restraint management and medication management were not satisfactorily addressed.

As part of the inspection the inspectors met with residents, relatives and staff members. The inspectors observed practices and reviewed documentation such as care plans, medication records, complaints logs, policies and procedures.

While the inspectors noted that many of the issues relating to medication management identified at the last inspection had been addressed, inspectors noted further issues of significant concern during this inspection with regard to the documentation of medicines administered in the centre. These issues were brought
to the attention of the provider and person in charge on the day of inspection and an immediate action plan was issued following the inspection. The action plan was responded to in a timely and comprehensive manner. The providers response indicated that immediate steps were taken to ensure safer systems were put in place.

The inspectors were concerned that there were still inadequate governance arrangements in place to maintain oversight of medication management, clinical assessment and nursing documentation.

On the day of inspection, the inspectors observed sufficient staffing and skill mix on duty. Residents spoken with told inspectors that staff were very kind and helpful.

The communal areas were appropriately furnished and the décor was pleasant. The inspectors observed residents taking part in a variety of activities.

The collective feedback from residents was one of satisfaction with the service and care provided.

The areas for improvement are contained in the Action Plan at the end of this report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

**Findings:**
An updated statement of purpose was submitted following the last inspection, it had been updated to accurately reflect the number of beds in the centre. However, the inspectors noted that some of the objectives set out in the statement of purpose were still not always reflected in practice such as adherence to best practice policies.

**Judgment:**
Non Compliant - Moderate

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**Outcome 02: Governance and Management**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A new person in charge had been appointed since the previous inspection, she had been in the post since early February 2015. The person in charge told inspectors that the provider was in the process of recruiting an assistant director of nursing to support her
While there was normally a clinical nurse manager (CNM) on duty who had responsibility for staff supervision, nursing care and the reviewing and overseeing of nursing documentation, they generally worked as a nurse on the floor and did not have supernumerary hours allocated to fulfil their management role.

There were systems in place to review some aspects of the safety and quality of care, and some improvements had been carried out since the last inspection. However, the inspectors were concerned that there were still inadequate governance arrangements in place to maintain oversight of all departments particularly medication management and clinical assessment and care planning to ensure the service is safe, appropriate to the residents needs, consistent and effectively monitored. These areas are discussed further under outcomes 7, 9 and 11.

**Judgment:**
Non Compliant - Major

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**Outcome 05: Documentation to be kept at a designated centre**

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

**Theme:**
Governance, Leadership and Management

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

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

**Findings:**

While there were written policies and procedures (Schedule 5), however, some of the policies were still not fully implemented in practice, such as medication management, managing behaviours that challenge and restraint policies. The inspectors noted that some records were not stored securely.

Some policies had been updated following the last inspection such as the complaints and restraint policies. A new cleaning policy had been developed. Staff spoken with were familiar and knowledgeable regarding these policies.

However, the inspectors noted that a large quantity of confidential records were stored insecurely in cardboard boxes in an unlocked room which was accessible to residents.
and visitors.

These are discussed further under outcomes 7 safeguarding and safety, 9 Medication management, 8 health and safety, 11 health and social care needs and 13 complaints.

**Judgment:**
Non Compliant - Moderate

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**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

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

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

**Findings:**
While the inspectors found that measures were in place to protect residents from being harmed or abused and improvements had been carried out to the management of residents finances, however, improvements were still required to the management of restraint and behaviours that challenge.

The inspectors noted that improvements had been made to the system in place for the management of residents’ finances. The person in charge kept small amounts of money for safe keeping on behalf of some residents. The inspector saw that this was securely stored and balances checked were correct. Deposits and withdrawals were witnessed and signed by two people. Receipts were available for all purchases.

Inspectors noted that the policy on behavioural management was still not fully reflected in practice. Inspectors reviewed the files of residents presenting with behaviours that challenged and noted that there were no behavioural assessments or monitoring charts on file as outlined in the policy. The provider told inspectors that she had attended one of a two day dementia and challenging behaviour training course and was due to attend day 2 following the inspection, she stated that this training was scheduled for staff in the nursing home on 23 April 2015.

The inspector reviewed the policy on the use of restraint dated November 2014 and found it to be comprehensive and based on the national policy ‘Towards a restraint free environment’. Nursing staff spoken with were knowledgeable regarding the policy and confirmed that they had received training from the provider on the implementation of the policy. However, the inspectors noted that this policy was not fully implemented or
reflected in practice.

The inspector reviewed a number of files of residents with restraint measures in place. There were 14 residents with physical restraint measures in place at the time of inspection. Quarterly returns notified to the authority indicated the use of chemical restraint for some residents. While a restraint register was maintained it did not include details of residents with chemical restraint measures in place and inspectors could not determine accurately the numbers of residents with chemical restraint measures in place. For one resident who had two care plans in place to guide the management of challenging behaviour and confusion/agitation however, there were no steps to clearly guide staff on the appropriate use of medications administered to this resident to manage the behaviours (e.g. diazepam).

Inspectors noted that risk assessments for the use of restraint were not fully completed. Alternatives to restraint that had been tried or considered and for how long used were not always included. The rationale for use of restraint was not always clear and there was no evidence to indicate that there had been multidisciplinary input into the decision to use restraint measures as per the centres policy on the use of restraint.

There was no risk assessment carried out prior to using a particular restraint measure in the case of one resident. The inspectors had concerns that a resident with bedrails in place had been assessed as being at high risk, the assessment indicated 'Do not fit bedrails' and there was no clear rationale documented or evidence of multidisciplinary input into the decision making process to use the bedrail. This was brought to the attention of the person in charge.

Judgment:
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 08: Health and Safety and Risk Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health and safety of residents, visitors and staff is promoted and protected.</td>
</tr>
</tbody>
</table>

| Theme: |
| Safe care and support |

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

| Findings: |
| The inspectors were satisfied that that issues relating to health and safety and infection control identified at the previous inspection had been addressed. |

Inspectors reviewed the risk register and noted that it had been updated following the last inspection to include risks identified. The risk register required further updating to include actions taken to minimise risks such as the new lighting provided at the outside water feature. However, the inspectors noted that the windows to a first floor unused
day room were fully open, window restrictors were not in use, the door to this room was unlocked which posed a potential risk to residents and visitors.

Potential risks identified at the last inspection had been addressed, the doors to the ground floor kitchenette, cleaners room, and laundry were secured and locked. All cleaning agents were labelled, a fire extinguisher was no longer located on the floor and free standing heaters were not in use. The inspector noted that laminated cards with details of type, size and colour of sling straps to be used for individual residents had been attached to hoists to ensure that staff used the correct hoist and sling.

The inspectors noted that smoking aprons were available to residents in the smoking rooms in line with the centre's own smoking policy.

The inspectors were satisfied that infection control and cleaning practices had improved. A cleaning policy and cleaning procedures had been documented to guide staff. Staff spoken with were knowledgeable regarding cleaning and infection control procedures. Staff confirmed that they had received training on the implementation of the cleaning policy since the last inspection. The building and equipment appeared visibly clean. The person in charge told inspectors of her plans to further enhance the cleaning process by allocating additional hours to cleaning during the day time and providing an additional cleaner at night time.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Some of the actions outlined following the last inspection had been addressed. The inspectors noted that a new prescription and medication administration sheet system was in use. All medications that were transcribed by nurses were now signed off by two nurses and by the general practitioner. Medications that were to be crushed were prescribed as such. Maximum doses of PRN (as required) medications were prescribed.

However, there were still issues of significant concern noted during the inspection with regard to the documentation of medicines administered in the centre. In the sample of medication administration sheets viewed by inspectors, there was a lack of documentation to account for the administration of a significant number of PRN (as...
required) psychotropic medications. Where medications were missing from the monitored dosage system many were not accounted for in residents’ medication administration sheets e.g. quetiapine, haloperidol, alprazolam. Nursing staff spoken with were unable to account for when or to whom these medications were administered to.

In addition, the inspectors noted that there were monitored dosage systems containing as required psychotropic medications that were no longer required on the medication trolley. Other medications which were no longer in use by residents were also stored either on the medication trolley or in the storage presses in the dispensary e.g. rectal diazepam, haloperidol injection, risperidone and lithium tablets. There was no regular procedure in place for returning medications no longer required to the pharmacy which resulted in the accumulation of unrequired medications. Medicinal products were also stored without a dispensing label to indicate for whom they were prescribed (e.g. zopiclone sleeping tablets and painkillers) and some tablets were missing from the boxes. A medicinal product that should be stored in the fridge was stored on the medication trolley.

There were discrepancies viewed between the prescription sheet and the medication administration sheet. For example, a nutritional supplement prescribed for twice daily administration was only being administered on a once daily basis.

**Judgment:**
Non Compliant - Major

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

**Findings:**
An inspector reviewed the incident log and noted that records were maintained of all incidents that took place in the centre. All incidents as required had been notified to the Chief Inspector since the last inspection.

**Judgment:**
Compliant
**Outcome 11: Health and Social Care Needs**

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

**Theme:**
Effective care and support

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

**Findings:**
The inspectors still had concerns that nursing documentation including clinical risk assessments and care plans did not always clearly guide staff. Residents had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

All residents had access to general practitioner (GP) services. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services and psychiatry of later life. Chiropody and optical services were also provided. The inspector reviewed residents’ records and found that residents had been referred to these services and recommendations were on file, however, residents care plans had not always been updated to reflect these recommendations.

Inspectors reviewed a sample of residents files including the files of residents with nutritional needs, weight loss, with restraint measures in place and presenting with behaviour that challenged.

The management of restraint was not in line with the centres own policy, this was discussed under outcome 7.

While there was a range of clinical risk assessments in place, however, care plans were not always updated to reflect updated assessments. For example, a mobility assessment indicated that a resident always required the use of a hoist, however, the care plan on impaired mobility indicated that staff should use a hoist if needed. Another resident had a care plan in place for high risk of falls which indicated that a low profiling bed and crash mat was in place, however a more recent assessment indicated that bedrails were now in place for this resident. In addition, the falls risk care plan had not been updated and there was no care plan in place for the use of the bedrails. A care plan to guide the
care of a resident with epilepsy had not been updated to reflect changes in a resident's medication. A care plan to guide the care of a resident with atrial fibrillation had not been updated to reflect changes in their medication.

There were no behavioural assessments or monitoring charts on the files of residents who presented with behaviours that challenged, this is discussed further under outcome 7.

A resident with a significant loss of weight loss (10kgs) over the past four month period had a dysphagia (swallowing difficulties) and dietary requirements care plan in place. The clinical assessment tool used by staff to assess the resident's risk of malnutrition; the malnutrition universal screening tool (MUST) had been updated. However, the care plan in place to guide the care of this resident was not person centred or informative. In addition, there was no reference in the care plan to this resident weight loss. While the resident had been reviewed by the SALT and more recently by the dietician, the care plan was not updated to reflect these recommendation's.

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:**
The operations manager provided the inspectors with an update in relation to the under floor heating issue from the last inspection. He advised inspectors that following the last inspection he had problems sourcing parts for the under floor heating system as the original contractor was no longer in business. He stated that he had since secured parts from Canada and remedial works were now in progress. He stated that works were due to be completed by 1 May 2015. The inspectors noted that electricians were on site at the time of inspection.

**Judgment:**
Compliant
### 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspectors reviewed the updated complaints policy. The complaints policy had been updated following the last inspection to include the name of the designated person complaints officer and the designated person to ensure that all records relating to complaints were maintained and all complaints were appropriately responded to.

However, the complaints procedure displayed had not been updated to reflect the updated complaints policy.

The inspectors reviewed the complaints log and noted that there had been no recent complaints.

**Judgment:**
Non Compliant - Minor

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

**Findings:**
Inspectors noted adequate numbers and skill mix of staff on duty at the time of inspection. On the day there were 96 residents living in the centre, one resident was in...
hospital. At the time of inspection there were four nurses and fifteen care staff on duty in the morning. There were three nurses and seven care staff on duty up until 22.00 hours and three nurses and five care staff on duty at night time. During the night time there was one nurse allocated to each floor and the third nurse was available to assist on either floor. The person in charge was normally on duty during the day time. The provider who was also a nurse was on duty four days a week.

Training records reviewed indicated that most staff had attended recent training in infection control and restraint management, eight nursing staff had attended training on nutrition and weight loss, 10 nursing staff attended medication management training and 4 nursing staff had attended resident record and care planning training. 45 staff had attended cleaning training. Staff spoken with confirmed that they had attended the training and found it to be beneficial. Further training was scheduled in dementia care and management of behaviours that challenge on 23 April 2015.

**Judgment:**
Compliant

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Mary Costelloe
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000729</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>21/04/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>25/05/2015</td>
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Requirements

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

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some of the objectives set out in the statement of purpose were still not always reflected in practice such as adherence to best practice policies.

Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
A revised Statement of Purpose will be submitted to the Authority

**Proposed Timescale:** 25/05/2015

### Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were still inadequate governance arrangements in place to maintain oversight of all departments particularly medication management and clinical assessment and care planning to ensure the service is safe, appropriate to the residents needs, consistent and effectively monitored.

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

**Please state the actions you have taken or are planning to take:**
Our present Management Team consists of a Director of Nursing with full time support from the Provider and 3 Clinical Nurse Managers. We are actively in the process of recruiting an Assistant Director of Nursing (Full Time), Practice Development Co-ordinator (part time) and another Clinical Nurse Manager (Full Time) to further enhance the Management Team Structure. This should ensure that the service is effectively monitored.

**Proposed Timescale:** 31/07/2015

### 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:**
Some policies were still not fully implemented in practice, such as medication management, managing behaviours that challenge and restraint policies.

**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:
The recruitment process alluded to in Outcome 2 should strengthen the Management team and allow for greater oversight of procedures and processes to ensure that all policies are implemented in practice.

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:
Some confidential records were not stored securely.

Action Required:
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

Please state the actions you have taken or are planning to take:
Records as described have been relocated to a locked room

Proposed Timescale: 26/05/2015

Outcome 07: Safeguarding and Safety
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the use of restraint was not fully implemented or reflected in practice.

The restraint register did not include details of residents with chemical restraint measures in place.

Risk assessments for the use of restraint were not fully completed, the alternatives tried or considered and for how long were not always included, rationale for use of restraint was not always clear and there was no evidence to indicate that there had been multidisciplinary input into the decision to use restraint measures as per the centres policy on the use of restraint.

There was no risk assessment carried out prior to using a particular restraint measure in the case of one resident.

A resident with bedrails in place had been assessed as being at high risk, the assessment indicated 'Do not fit bedrails' and there was no clear rationale documented or evidence of multidisciplinary input into the decision making process to use the
bedrails.

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

**Please state the actions you have taken or are planning to take:**
All cases where restraint is in use have been reviewed to ensure that documentation to include risk assessment, multidisciplinary input etc. is correct, guides practice and is now in line with policy. The Restraint register has been updated accordingly.

**Proposed Timescale:** 26/05/2015

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**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk register required updating to include actions taken to control risks such as the new lighting provided at the outside water feature. The windows to a first floor unused day room were fully open, window restrictors were not in use, the door to this room was unlocked which posed a potential risk to residents and visitors.

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

**Please state the actions you have taken or are planning to take:**
Risk register has been updated to include hazards identified on the day of the inspection and controls put in place

**Proposed Timescale:** 26/05/2015

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**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
In the sample of medication administration sheets viewed by inspectors, there was a lack of documentation to account for the administration of a significant number of PRN (as required) psychotropic medications. Where medications were missing from the
monitored dosage system many were not accounted for in residents’ medication administration sheets e.g. quetiapine, haloperidol, alprazolam. Nursing staff spoken with were unable to account for when or to whom these medications were administered to.

There were discrepancies viewed between the prescription sheet and the medication administration sheet. For example, a nutritional supplement prescribed for twice daily administration was only being administered on a once daily basis.

A medicinal product that should be stored in the fridge was stored on the medication trolley.

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

**Please state the actions you have taken or are planning to take:**
We have reviewed and enhanced our documentation and recording of P.R.N. psychotropic medication administered. All medications are now clearly accounted for.

In conjunction with the Pharmacist we have conducted a review of Prescription sheets and medication administration record to ensure that there are no discrepancies.

Nursing Staff have been reminded about correct storage of medications.

**Proposed Timescale:** 26/05/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The inspectors noted that there were monitored dosage systems containing as required psychotropic medications that were no longer required on the medication trolley. Other medications which were no longer in use by residents were also stored either on the medication trolley or in the storage presses in the dispensary e.g. rectal diazepam, haloperidol injection, risperidone and lithium tablets. There was no regular procedure in place for returning medications no longer required to the pharmacy which resulted in the accumulation of unrequired medications.

**Action Required:**
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no
longer be used as a medicinal product.

**Please state the actions you have taken or are planning to take:**
A Clinical Nurse Manager on each floor has been assigned the responsibility of checking weekly that all medication no longer in use is returned to the pharmacy and that any returns are documented and countersigned upon receipt by pharmacy staff

**Proposed Timescale:** 26/05/2015

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## 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:**
While there was a range of clinical risk assessments in place, care plans were not always updated to reflect updated assessments. For example, a mobility assessment indicated that a residents always required the use of a hoist, however, the care plan on impaired mobility indicated that staff should use a hoist if needed. Another resident had a care plan in place for high risk of falls which indicated that a low profiling bed and crash mat was in use, however a more recent assessment indicated that bedrails were now in place for this resident. The falls risk care plan had not been updated and there was no care plan in place for the use of the bedrails. An care plan to guide the care of a resident with epilepsy had not been updated to reflect changes in a residents medication.

**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:**
With the co-operation of our Nursing Staff we are in the process of a review and update of all care plans for residents. This will ensure that the information contained therein is person centred, accurate and informative. This major project commenced in early May and is almost 70% complete

**Proposed Timescale:** 30/06/2015

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**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The care plan in place to guide the care of a resident with significant weight loss was
not person centred or informative. There was no reference in the care plan to this resident weight loss. While the resident had been reviewed by the SALT and more recently by the dietician, the care plan was not updated to reflect these recommendation’s.

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

**Please state the actions you have taken or are planning to take:**
With the co-operation of our Nursing Staff we are in the process of a review and update of all care plans for our residents. The particular care plan referred to above has been fully reviewed and information contained therein is person centred, informative and any MDT recommendations have been fully incorporated into the care plan.

**Proposed Timescale:** 30/06/2015

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**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:**
The complaints procedure displayed did not reflect the complaints policy.

**Action Required:**
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
Complaints Procedure has been updated and is now in line with the policy

**Proposed Timescale:** 26/05/2015