<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Woodlands House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000186</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Trim Road, Navan, Meath.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>046 902 8617</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:woodlandshousenh@gmail.com">woodlandshousenh@gmail.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>Sandcreek Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Fintan O'Connor</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>N/A</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>21</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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</thead>
<tbody>
<tr>
<td>31 March 2015 09:30</td>
<td>31 March 2015 18:00</td>
</tr>
<tr>
<td>01 April 2015 09:30</td>
<td>01 April 2015 16:30</td>
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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**

This inspection was completed in response to an application by the provider for renewal of registration under the Health Act 2007. This was the sixth inspection of the centre since April 2014 and the twelfth inspection overall by the Authority.

The Authority has been involved in on-going regulatory activity with the provider due to findings of major non-compliance with the regulations since July 2014. As a result of finding in July 2014, a regulatory meeting was convened by the Authority with the provider/person in charge and the two directors of the company on 30 July 2014. A follow-up monitoring inspection was completed in September 2014 and resulted in an regulatory escalation activity including;
- An immediate action plan being issued to the provider/person in charge referencing lack of referral of residents for behavioural and physiotherapy expertise and inadequate evacuation arrangements in the event of a fire in the centre. The provider/person in charge provided supporting evidence of her immediate response to same.

- A Warning Letter was issued to the provider on the 24 October 2014 due to findings of on-going non-compliances with the Legislation.
- A further inspection was completed in November 2014 where there was evidence that the provider was addressing inadequate fire safety and evacuation procedures in the existing centre in collaboration with Meath Fire Services. However, findings evidenced that evidence based best practice in relation to care of residents with challenging behaviour, promotion of limb function and management and unintentional weight loss were not adequate.

- The Authority convened a further regulatory meeting with the provider and person in charge on 04 December 2014. In response, the provider revised the organisational structure of the centre in terms of governance and management arrangements. The provider forwarded a revised statement of purpose and transferred all residents from the existing centre into the new extension under the existing registration conditions. The provider also ceased admissions to the centre in December 2014 to complete transfer of residents to the new purpose-built extension.

The premises provides accommodation for a capacity of 30 residents within 24 single rooms and 3 twin rooms, the provider has previously applied for a variation of accommodation arrangements to increase the current registered 22 beds to 30 beds. Progression of this application was suspended following the application for variation in November 2014 due to major non-compliances in relation to inadequate fire safety and resident care procedures which have been satisfactorily resolved.

The inspector observed and was told by residents spoken with that the new purpose-built centre facilities significantly improved their quality of life, independence and comfort. This finding was also confirmed by residents/relatives’ comments in the Authority’s pre-inspection questionnaires

The inspector spoke with residents and staff members. Documentation including policies, care plans, risk management documentation and records, fire safety records, staff duty rotas and training and audits was also reviewed. Inspector observed staff practices and followed up on progress with completion of action plans from the last inspection of the centre in January 2015.

All eighteen outcomes were assessed on this inspection. Findings supported that substantial work completed to date brought the centre into compliance with the legislation in eight outcomes. Six outcomes were in substantial compliance and the remaining four outcomes were in moderate non-compliance with the legislation. Areas of moderate non-compliance included;

- documentation to be kept in the centre
- safeguarding and safety of residents,
- health and safety and risk management,
- workforce.
Residents spoken with told inspectors that they were happy and comfortable in the centre and were satisfied with the care provided. They also said they felt safe and were complimentary of the staff caring for them. Staff interactions with residents were observed by the inspector and found to be warm, patient, helpful and kind on the days of inspection.

The Action plan at the end of this report identifies mandatory improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A revised statement of purpose document dated March 01 2015 was viewed by the inspector, available to residents and forwarded to the Authority as required. The document references the revised organisational structure with Fintan O'Connor as provider nominee and Susan Walsh as person in charge of the centre. The provider advised the Authority of transfer of resident accommodation to a new purpose-built extension from the existing centre in January 2015. This resident accommodation transfer was done within the current conditions of registration to include a maximum occupancy of 22 residents.

**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
The governance and management structure in the centre had been revised with nomination of director, Fintan O’Connor as provider nominee and Susan Walsh as person in charge. These changes were appropriately notified to the Authority following a regulatory meeting on 04 December 2014. The provider ceased admissions to the centre from 04 November 2014 to facilitate work to bring the centre into compliance with the legislation and transfer of residents to a new purpose built extension to mitigate risk posed by the existing centre premises and emergency arrangements.

On this inspection, the inspector found evidence of implementation of monitoring systems, although at an early stage to ensure the quality and safety of care and quality of life for residents in the centre was. There was evidence of robust actions taken to address deficits found on previous inspections and in response to action plans. For example, a comprehensive cleaning service was implemented in addition to staff training in a number of areas of clinical practice to ensure staff competency.

There was improvement in the clinical governance of the centre since January 2015. The inspector found that residents' healthcare needs were met on this inspection. The inspector also found that the needs of residents with challenging behaviour were adequately supported with responsive and progressive positive behavioural programmes that built on progress made to date.

While incomplete, there was adequate evidence that the person in charge was reviewing all policies and procedure to ensure this documentation informed evidence-based practice in the centre.

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

Findings:
The residents guide document was revised since the last inspection in November 2014 to reference the new resident accommodation and was provided to new and current residents for their information. The document referenced the information as specified by the Regulations.

Contracts of care were revised on March 01 2015. A sample of resident contracts was
reviewed on the day of inspection and was found to set out the services to be provided and the fees to be charged in most cases. However, a number of contracts reviewed did not specify the costs of additional services or the arrangements for same which were not included in the fee. For example, costs of allied health professional consultation and staff escort to appointments which may be required to ensure residents’ healthcare needs were met were not clearly specified. Some residents signed their agreement with their own contracts.

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:
Susan Walsh is a registered general nurse with An Bord Altranais agus Cnáimhseachais na hÉireann. She has the required experience in caring for older people as described by the Legislation.

The person in charge demonstrated that she was engaged in the governance, operational management and administration of the centre on a full-time basis over five days each week. Susan Walsh has completed a postgraduate course in gerontological nursing and demonstrated attendance at further education courses and training days to inform her professional knowledge and skills. The person in charge is supported in her role by a senior staff nurse who deputised in her absence, a full-time general manager, staff nurses, carers, catering, household and administrative staff

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

**Findings:**
Inadequate residents' care plan documentation was the subject of an action plan on the last inspection in January 2015 and was improved on this inspection as found in the sample of residents care plan documentation reviewed.

An absence of time on the duty rota was identified on the last inspection for improvement to ensure continuity of communication and was found to be complete on this inspection.

While policies and procedures were available to guide practice and there was evidence from review that a number had been updated and reviewed by the provider and person in charge since the last inspection. However, this action was not satisfactorily completed within the timescale proposed in the provider response to the action plan. This action is repeated in the action plan with this report and requires the person in charge to set a new timescale to ensure evidence based guidance documentation is available to inform staff practice and procedures as required by Schedule 5 of the regulations.

A list of residents' personal possessions was maintained including furniture and personal items which was kept updated. Policy documents were available, both reviewed on the 09 March 2015, to inform residents' personal possessions and finances. The inspector reviewed the process for recording and safekeeping residents personal money kept in safekeeping on their behalf. While records were maintained of each transaction which was double signed and the balances checked by the inspector were correct, the information was difficult to navigate and posed a risk of omission error. The provider and person in charge agreed that this required review which they would undertake to maintain each resident's money valuables and record of transactions together. This finding is not in compliance with Schedule 3, Paragraph 5(b)

The directory of residents contained the information as specified in Schedule 4, Paragraph 12.

Documentation to be maintained in respect of each staff member was in place as required by Schedule 2.

**Judgment:**
Non Compliant - Moderate

**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:**
Arrangements were in place for management of the centre by a deputy in the event of the person in charge being absent. There were no occasions where the person in charge was absent to date for greater than 28 days.

**Judgment:**
Compliant

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

**Findings:**
Some residents in the centre presented with varying levels of challenging behaviours. Management of these residents' behaviours was the subject of action plans in all inspections since July 2014. On this inspection, the Inspector found evidence that there were positive outcomes for these residents following proactive management including input from allied health professionals and change of environment since the last inspection in January 2015.

A deficit in staff training in challenging behaviour was identified on the last inspection in January 2015 to ensure staff were adequately informed to maintain and promote progress made in this area. The inspector reviewed staff training records and found that additional training ensured all staff were informed in this aspect of resident care. 80% of staff had completed management of challenging behaviour and 40% had completed person centred dementia training. There was a comprehensive policy to inform management of residents with challenging behaviour.
The inspector found that use of restraint measures for some residents was appropriately assessed and monitored on this inspection. There was evidence of trialling of alternative, less restrictive measures and residents' safety requirements was evaluated as part of their restraint assessment with use of a recently introduced risk/balance analysis tool to aid this process. Restraints were used for specified timescales and the inspector observed example of one of these schedules in action for one resident who used a fixed over-chair table. The resident's fixed over-chair table was removed on a number of occasions throughout the day and the resident was assisted to walk for specified distances by staff. This intervention was in place to ensure any potential negative impacts posed by the restraint used on quality of life, limitation on independence and mobility was mitigated and was documented in the resident's care plan. A policy was in place to advise staff on restrictive measures was available dated 10 March 2015. There was one resident who was prescribed for PRN (as required) chemical restraint which was used on the week prior to the inspection. The documentation evidenced use of same within a de-escalation framework however, there was no documented protocol available to advise on appropriate use or review procedure to ensure appropriate use was observed as part of this residents behavioural support plan.

The centre is fitted with a closed circuit television (CCTV) security system. While there were cameras fitted on corridors, there were no cameras in residents' private accommodation or in communal areas used by residents. Use of CCTV was advertised appropriately and use of same was informed by a policy document. The entrance to the centre was secure and access was controlled by a recently appointed receptionist during office hours and by staff outside of same.

Two volunteer staff working in the centre had their roles clearly specified and were appropriately supervised and vetted by An Garda Siochana. A policy document was available to inform protection of vulnerable persons. There were no incidents or allegations of abuse documented and this finding was confirmed by the Person in Charge. Staff-resident interactions were observed to be satisfactory on the days of inspection and residents confirmed to the inspector that they felt safe in the centre. Staff spoken with were knowledgeable regarding appropriate procedures to follow in the event of an allegation or evidence of abuse. However, four staff were not recorded as having attended protection of vulnerable persons training as required by regulation 8.

A list of residents' personal possessions was maintained including furniture and personal items which was kept updated. Policy documents were available; both were reviewed on the 09 March 2015, to inform residents' personal possessions and finances. Recording and safekeeping of residents' personal money kept in safekeeping on their behalf, while correct required review to improve accessibility of this information. This finding is discussed in outcome 5 of this report.

Judgment:
Non Compliant - Moderate
Theme: Safe care and support

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

Findings:
A revised safety statement was available on this inspection. This document was referenced as reviewed in December 2014 and described the health and safety arrangements in the centre. Quarterly health and safety meetings were convened, the most recent being held on 24 March 2015. These meetings were minuted and there was signatory evidence that staff had read same.

A risk management policy was available. There was a risk register that identified all risks in the centre and included stated concomitant controls to mitigate risks found. Risks found on the last inspection were adequately mitigated. There was evidence that review of the accidents and incidents informed the risk register. The process demonstrated that there was learning from the incidents and accidents stated in the controls in place to mitigate risk of recurrence.

The risk management policy included sub-policies advising on management of aggression and violence but required review as it did inform management of incidents of resident to resident aggression. Advisory information on management and prevention of self harm, abuse and accidental injury to residents, visitors and staff was available. Procedures advising on management of unexplained absence of a resident required review to include information on development of identification profiles for residents at risk of leaving the centre unaccompanied.

A record of accidents and incidents to residents was maintained in the centre. From a review of the accidents and incidents from 01 December 2014 to the 28 February 2015, the inspector observed that 75% of resident falls occurred between 20:30 and 02:00hrs, one of which resulted in a fractured thumb. This finding is discussed further in Outcome 18 of this report.

An action from a previous inspection which related to safe access to the centre while building work was under way was found to be resolved on this inspection. Access from the road into the new extension was observed to be clear. The kitchen was fully refurbished and integrated into the centre and risks posed with transportation of residents’ food in a bain maire were resolved. This finding is discussed further in outcome 15.

Hand hygiene facilities were provided with appropriate hand wash sinks and hand gel stations. Staff completed hand hygiene as appropriate. The infection prevention and control policy was under review at the time of inspection. The draft document did not reference advisory procedures to inform management of an infection outbreak. 83% of staff had completed infection prevention and control training.

An environmental and equipment cleaning procedure folder was available which included
cleaning schedules based on level of risk. The information referenced clear cleaning procedures instructions. The centre was visibly clean and free of malodour. A new cleaning trolley was purchased and in use which ensured that cleaning solutions were transported and stored securely. Monthly auditing of the environment and sluice equipment was completed which evidenced a 96% compliance rate.

An emergency policy was available and was recently updated. As a control to mitigate risk posed by the original building structure to residents in relation to fire safety, the provider facilitated all residents to transfer to the current accommodation which is purpose-built. Ten staff had completed fire marshal training. Preventative fire checking procedures were completed. Fire drills were simulated to ensure residents could be safely evacuated at all times of the day and night. Fire drill records were maintained and were comprehensively documented. Staff training records referenced that all members of staff had attended fire safety training and had participated in a fire drill. All residents had personal evacuation plans developed that assessed and informed their evacuation requirements in terms of staff numbers and equipment including equipment to support continuity of treatment that should remain with them in the event of evacuation being required.

All fire exit doors were locked with electromagnetic units which the provider advised the inspector were designed to disengage on activation of the fire alarm. Final fire doors were operated by a push-bar mechanism. All fire exits were free of obstruction on the day of inspection. Bedroom doors were fitted with self-closure units. Fire exit directional signage was visible on exiting each room. Fire safety lighting was visible in all areas used by residents including bedrooms. Fire procedure notices were displayed.

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 was a medication management policy available to inform practice. The medication management policy required review to include procedures for return of unused medications and pain assessment. This finding is discussed in outcome 5 of this report. The inspector attended a medication round and carried out a review of a sample of medication prescription and administration records belonging to residents in the centre. The inspector found that medications were administered to residents in line with professional practice standards and in line with legislative requirements. Procedures for recording of medication variance was recently reviewed and implemented. A protocol for
administration of PRN (as required) psychotropic medication was not in place to inform administration as part of a behavioural support process. This finding is discussed in outcome 7.

A pharmacist attended the centre and was available to residents to inform and advise them on the actions of their medication treatments. The pharmacist's availability was displayed on the notice board for residents' information. The pharmacist completed quarterly medication audits in line with their pharmaceutical obligations. Each resident’s medications including medications controlled under the Misuse of Drugs legislation were stored securely in a clinical room in an area adjacent to the nurses' station. There was evidence of appropriate balance checking procedures of controlled medications.

A medication refrigerator was available, the temperature of which was checked and recorded.

Judgment:
Substantially Compliant

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

**Findings:**
A record of all incidents including incidents to residents was maintained in the centre. Quarterly notifications and notifications of serious injury had been submitted to the Authority as required and within the appropriate timeframe but did not include details of PRN (as required) chemical restraint used.

The person in charge was aware that she was legally obliged to notify the Chief Inspector of incidents as required.

Judgment:
Substantially Compliant

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

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

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

Findings:
The person in charge routinely assessed residents’ dependency levels every three months or more often in response to a change in their needs. On the days of this inspection, there were seven residents with maximum, three with high, nine with medium and two with low dependency needs. Seven residents has dementia care needs.

The inspector reviewed a sample of residents’ care plans and documentation with reference to findings on the last inspections in January 2015. The Person in Charge and deputy Person in Charge commenced a process of reviewing two residents' care plans each week since the last inspection in the centre in January 2015. Inadequate residents' care plan documentation was the subject of an action plan on the last inspection in January 2015 and was found to be satisfactorily completed in the sample of residents care plan documentation reviewed on this inspection. Daily progress notes were completed and were adequately linked to care plans.

The inspector found evidence of improvement in care provided and the quality of life for residents in their new environment on this inspection. On this inspection, referral and consultation by allied health professionals as appropriate was in place to support care provided by staff for residents with healthcare needs. There was evidence that recommendations made by Allied Health Professionals were incorporated into the care of the sample of residents reviewed.

While an assessment tool was used to monitor and manage residents' pain, the medication management policy did not inform this practice. This finding is discussed in outcome 5.

The Inspector found from a review of a sample of care plans on this inspection, that all residents' assessed needs had a documented care plan in place to inform required care interventions. The inspector discussed residents’ needs with the Person in Charge and her deputy and both were knowledgeable regarding residents' needs. Care provided was observed to be evidence based, although a number of policy document information required review as discussed in outcome 5.

Residents care plans were regularly reviewed and there was evidence that residents or their next of kin were involved in this process. One resident had a skin grafted surgical wound managed with appropriate assessment and dressing schedule documentation in place. Monitoring of this resident's wound was ensured by facilitation to attend outpatient appointments.

There were procedures in place for admission and temporary discharge of residents. The directory of residents’ document was observed to record admission, discharge and periods of temporary absence by residents for example, admission to hospital.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The structure and layout of the centre premises, having regard to needs of residents, was found to conform to the matters set out in Schedule 6 of the Regulations and Standard 25 of the National Standards.

The kitchen was fully completed and commissioned into the new premises on this inspection as it incorporated part of the existing kitchen. The kitchen opened into a newly constructed dining room which was in use by residents. The original house was closed off from the designated centre and residents were protected from unaccompanied entry into the same by a secured door. The provider and person in charge confirmed to the inspector that the front door of the original building was no longer used as an access point to the designated centre. The designated centre had independent access provided.

The designated centre provided a secure internal courtyard. Lighting was fitted at various points to illuminate the perimeter. Surrounding roadway surfaces were covered by tarmacadam and emergency vehicle and car-parking space marking was completed.

All equipment for use by residents was clean and in working order including hoists, a weighing scale chair, pressure relieving mattresses and motors and residents’ call bells. Residents who were resting in bed had their call bells within close proximity to them. The centre was fitted with assistive equipment to meet the needs of the residents in the centre. Handrails were fitted along corridors to assist residents with mobility needs. The centre was well lighted and orientation cues were in place to assist residents with navigating the centre. There was a variety of communal sitting areas and a dining room provided to residents to meet their needs.

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

**Findings:**
A complaints log was in place which included records of verbal dissatisfaction expressed. Review of areas of dissatisfaction logged was demonstrated with actions in place to address same. There were no active complaints under investigation on the days of inspection. There was a complaints procedure in place in the centre which was displayed. Review of this document was required to ensure the appeal procedure was clear where satisfaction with the outcome of internal investigation was not obtained.

Residents spoken with confirmed they were aware that they could make a complaint if dissatisfied with any aspect of the service. Residents and relatives also expressed their satisfaction with the service provided in the Authority's pre-inspection feedback questionnaires. Residents told the inspector that they knew who to make a complaint to and felt they would be listened to. An advocacy service was available to residents who required assistance.

**Judgment:**
Substantially Compliant

### 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 was one resident in receipt of end of life care on this inspection. The inspector observed that this resident's care needs were documented in a care plan. A review of a sample of residents' care plans evidenced that their end of life wishes were discussed and documented where they wished to disclose this information. Members of the local
clergy from the various religious faiths provide pastoral and spiritual support to residents including those at the end stage of their lives. There was a policy document available to inform residents' end of life care in the centre. Palliative care services were available on referral to assist with promoting residents' comfort needs. The staff training records evidenced that approximately 50% of staff had attended end of life care training.

The centre had arrangements in place to provide accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time. The person in charge confirmed that residents residing in twin rooms would be provided with single room accommodation at the end stage of their lives.

**Judgment:**
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:**
Residents dined in a new purpose-built dining room located adjacent to the newly refurbished and commissioned kitchen on the days of inspection. There was adequate space for all residents to dine together if they wished in this area. The inspector found that residents' nutritional needs were met. Residents had satisfactory access to adequate nutrition and hydration to meet their needs. The inspector observed a lunchtime meal on one of the days of inspection. Residents had access to two hot meal choices displayed for their information on a menu board and on menus placed on each table. The inspector observed that the dining experience was a social occasion used by residents to chat with others over their meals. Residents spoken with and residents' feedback in pre-inspection questionnaires confirmed satisfaction with the service provided. Residents had ready access to fresh drinking water from water dispensers available in addition to a choice of drinks supplied at intervals throughout the day and at mealtimes. The inspector observed staff offering residents a choice between a clothes protector or disposable napkin. Some residents were provided with assistive eating equipment prescribed to meet their needs. The inspector also observed that assistance was provided discreetly and sensitively to residents who required same with eating/drinking at mealtimes.

Weighing equipment was available, calibrated and in working order on the days of
inspection. An inspector also observed where a dietician had reviewed calorific values of ingredients and resident menus to inform residents' food preparation, dietary intake records and food fortification activity. There was evidence of appropriate referral of some residents for assessment by the speech and language specialist. Some residents were provided with modified consistency food in line with recommendations made. Food fortification and preparation of modified consistency foods was completed in the kitchen by the catering staff. The inspector found the chef to be well informed regarding residents' individual requirements as recommended by the dietician/speech and language therapist. There was satisfactory evidence of monitoring of fluid and food intake for residents at risk of unintentional weight loss. Weights were recorded and documented in addition to calculation of residents' BMI (basal metabolic rate) to ensure their nutritional needs were met. The inspector spoke with the dietician on one of the days of inspection who demonstrated her role in the centre.

A policy document was available to inform staff with meeting the nutritional and hydration needs of residents dated 27 November 2014. Staff training included attendance by most staff at training on nutrition and dysphagia, nutrition and dementia, use of the nutrition assessment tool and food hygiene.

Judgment:
Compliant

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

Findings:
On this inspection, the inspector found evidence that residents' rights, privacy, dignity and consultation needs were met. Challenges with maintaining the privacy and dignity of a resident with challenging behaviours that negatively impacted on their privacy and dignity were found to be overcome on this inspection with satisfactory management and quality of life strategies in place.

The inspector observed and was told by residents that the new purpose-built centre facilities significantly improved their quality of life, independence and comfort. The facilities ensured residents could receive care in a way that promoted their privacy and dignity in single and twin rooms, each fitted with an en-suite shower, toilet and hand-
wash basin. Bedroom windows were fitted with net curtains and twin bedrooms had adequate bed screening/personal space available to ensure residents could conduct personal care in private. The exterior of residents’ bedroom windows located on walls in the internal courtyard and a window on a quiet sitting room overlooking a children’s playground was covered with a material that obstructed view inwards but did not prevent view outwards.

There was evidence on this inspection that residents were supported and encouraged to make informed choices about their day to day lives in the centre. Staff were observed to support and encourage independent and informed choice. Residents’ meetings were held on a quarterly basis and were chaired by a volunteer worker. These meetings were minuted. The minutes reflected input by residents in discussion about their new accommodation and their satisfaction with it. The provider and person in charge told the inspector that they welcomed residents’ feedback and demonstrated they were taking action to make the residents’ new accommodation homely and comfortable. Actions taken in this regard since the last inspection in January 2015 included installation of a new dining room which provided additional area for residents to sit and relax in the sitting room. Installation of additional notice-boards with information for residents, decorative fixtures and fittings and personalisation of residents’ bedrooms was observed to enhance the comfort of residents.

Advocacy services were documented as being available to residents. Two volunteers referred to as ‘befrienders’ also attended the centre and visited residents. There was documented evidence that vetting was completed to ensure residents’ safeguarding needs were met. While there was no designated visitors’ room, there was a variety of areas available to residents in their new accommodation to meet their visitors in private outside their bedrooms if they wished.

The inspector spoke with the activity co-ordinator and observed facilitation of communal recreational activities on the days of inspection to meet the needs of two resident groups with contrasting needs and capabilities. In response to findings during recent inspections and resident feedback in a satisfaction survey where a number of residents expressed disinterest in/dissatisfaction with the activities provided, provision of recreational activities was reviewed. The inspector was informed and observed that the activity co-ordinators working hours were increased and she had commenced an accredited sensory based activation course suitable for residents with dementia care needs. Documentation referencing each resident’s level of participation in activities provided was being collated to assess whether the activities provided met the interests and capabilities of each resident. However, the inspector observed that this documentation recorded attendance and did not comprehensively inform level of participation or positive outcomes for some residents in meeting their individual interests.

A communication policy was in place to advise staff on ensuring residents with communication difficulties had their needs met in this area. The inspector observed that signage in place to communal areas also included pictorial cues. Residents with vision and hearing needs were referred appropriately for assessment and assistive equipment.

Trips outside the nursing home are offered to residents. Some trips in the past were
organised for residents to go shopping and to local areas of interest including ornate gardens, to readings in the library and the garden centre located within close proximity to the centre. Some residents also go out with their family on social occasions.

Residents were facilitated to practice their religious beliefs. Clergy of different faiths visited the centre and were available to residents. A Mass was organised every two weeks and a Eucharistic minister attended the centre weekly.

Judgment:
Substantially Compliant

**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:**
The inspector found that all residents had adequate space to store their clothes and personal belongings and could maintain control and access to same at all times.

There was a policy to inform management of residents' personal property and possessions available. A record of each resident’s property was completed but was completed to ensure possessions were recorded. Residents spoken with told inspectors that they never lost any possessions in the centre. The centre has a laundry on-site and residents clothing was laundered by designated staff. Linen collection skips were available that appropriately segregated used linen in line with the national policy. Residents spoken with told the inspectors that their clothing was managed to their satisfaction. The inspectors observed that clothing worn by residents was clean, in good condition and stored neatly in wardrobes and drawer units. Items of residents clothing viewed by the inspectors had the residents identification on them.

Judgment:
Compliant

**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an
appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

**Theme:**
Workforce

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

**Findings:**
The person in charge was scheduled in the centre as on duty each day from 09:00hrs to 18:00hrs, a staff nurse was scheduled on duty from 08:00hrs to 20:00hrs, four carers were on duty in the morning which reduced to three carers from 14:00hrs to 21:00hrs. A staff nurse and two carers were scheduled on each night duty. All staff were documented on the copy of the staffing rota viewed by inspectors including the hours of duty of the provider nominee. There was evidence that additional staff had been appointed including a full-time receptionist since the last inspection in January 2015. On the inspection in January 2015, an additional carer was rostered on night duty, additional cleaning staff for 3 hours each day at the weekends and the activity coordinator worked an additional hour each day (5 days per week). While, the inspector observed that residents were adequately supervised and assisted on the days of inspection with call bells answered promptly, evidence found in relation to times of resident falls indicated that review of staffing levels/skill mix was required to ensure residents needs were met between 20:00hrs and 02:00hrs. This finding also requires review to ensure adequate staffing resources can be provided in terms of the provider’s application to increase resident occupancy from 22 to 30 residents. The provider was advised that a detail of planned staffing and skill mix was required by the Authority to support application for increased occupancy.

There were arrangements in place to ensure all staff were adequately supervised. Staff nurses working on night duty also worked on day duty ensuring appraisal/performance management could be completed.

Staff training records confirmed that staff were facilitated to maintain their professional development, knowledge and skills by their recorded attendance at a range of clinical and care updates that reflected the profile and clinical conditions of residents in the centre. The inspector on review of training records provided found that some staff had not completed mandatory training in protection of vulnerable persons as required. This finding is discussed in outcome 7 of this report.

Confirmation that all nurses employed in the centre was provided and staffing numbers recorded on the duty rota correlated with the staffing resources provided as referenced in the centre’s statement of purpose.
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:

Catherine Rose Connolly Gargan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
**Health Information and Quality Authority Regulation Directorate**

**Action Plan**

**Provider’s response to inspection report**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Woodlands House Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000186</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>31/03/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29/05/2015</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 02: Governance and Management**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Improved management systems were required to provide evidence based policies and procedures to inform practice and ensure service is consistent and effectively monitored.

**Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
1) The Providers Nominee has instituted a new Performance Appraisal Meeting on a monthly basis.
   This meeting will include key staff.
   The meeting focuses on 4 key aspects of the service provided:
   a) Residents care implementation, other issues
   b) Risk - new identified risks,
   c) Staff...aspects such as training, new staff,
   d) Operations including Kitchen, Cleaning, reception.
   The purpose of the meeting is to identify any issues and monitor key parameters so as to facilitate informed decision making.

2) In addition Policies and Procedures across all areas continue to be reviewed by the PIC and deputy PIC and General Manager.

3) The PIC undertakes additional audits on a regular basis which are consistently implemented to improve the safety, appropriateness and monitoring of the service provided.

4) Quarterly report compiled by PIC to review safety, appropriateness and monitoring of the service and to inform future action

Proposed Timescale: 29/05/2015

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:
Some contracts of residency did not specify the costs of additional services or the arrangements for same which were not included in the nursing home fee.

Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
Any additional costs which heretofore have not been charged for have been identified.
The Providers Nominee in conjunction with the PIC and General Manager will
a) Provide updated addition containing relevant information to all residents and next of kin.
b) Update information has been posted on relevant notice boards.
c) Residents Guide has been update to show any additional costs.

Proposed Timescale: B, C complete, A in process completed June 30th.

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

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**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:**
A number of policies and procedures required updating to ensure they informed practice in the centre.

The medication management policy did not reference development of a protocol for use when administering PRN (as required) psychotropic medication or the requirement for use of a pain assessment tool in managing residents' pain.

**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 PIC has developed a comprehensive policy relating to the administration of PRN psychotropic medication and updated the medication management policy accordingly.

GP’s will continue to document clear instructions on the prescription sheet regarding the appropriate use of this PRN psychotropic medication as before.

Nursing staff have been reminded of their responsibilities regarding same and to continue as before with clear adherence to the GP’s instructions.

The PIC has developed an appendix to the medication management policy regarding the requirement for use of a pain assessment tool.

The PIC has advised staff of the requirement for the use of same.

**Proposed Timescale:** 29/05/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Procedures for recording residents money deposited for safekeeping required review as required by Schedule 3, Paragraph 5(b)

**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:**
The General Manager and PIC have reviewed the procedure for recording financial transactions involving residents.

A new procedure has been developed and implemented whereby residents will from now on have their own individual record book of their transactions.

Staff have been reminded of the necessity to ensure signatures are recorded in respect of each transaction.

**Proposed Timescale:** 29/05/2015

**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:**
There was no documented protocol available to inform appropriate use or review procedure to ensure appropriate use was observed as part of this residents behavioural support plan.

**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:**
The PIC has developed a new protocol regarding appropriate use of PRN chemical restraint. This has been adopted and implemented as part of this resident’s behavioural support plan and a policy implemented on the use of psychotropic medications. This is in addition to the existing Policy titled “Guideline for Emergency Chemical Restraint which has been in place since the beginning of 2015.

In addition a new review procedure to ensure appropriate use has been appended to the Medication Management Policy.

All nursing staff have been reminded of their responsibilities in this regard and have been advised of the new policy and procedure.
The training plan for 2015 includes further training on the use of restrictive procedures and Dementia Care.

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<th>Proposed Timescale: 29/05/2015</th>
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<td><strong>Theme:</strong> Safe care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Four staff were not recorded as having attended protection of vulnerable persons training.

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

**Please state the actions you have taken or are planning to take:**
The PIC has reviewed staff training records.

Any Staff member not fully up to date with relevant training has been identified.

All outstanding training in this area has been scheduled for completion by end June 2015.

Training needs will be monitored on a monthly basis by the PIC and Providers Nominee.

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<th>Proposed Timescale: 30/06/2015</th>
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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:**
Procedures advising on management of unexplained absence of a resident required review to include information on development of identification profiles for residents at risk of leaving the centre unaccompanied.

**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:**
The PIC in conjunction with the General Manager have reviewed all residents risk
profiles.
The risk management policy has been reviewed to include additional measures and actions to control unexplained absences incorporating CCTV and receptionist role. A new and separate Identification profiles have been compiled on any resident felt to be at risk of absconsion

The PIC has updated the existing policy relating to missing persons to include the new absconsion risk profiles as identified in the above exercise.

All staff have been advised of the new profiles and reminded of the dangers and risks associated with the unexplained absence of any resident.

**Proposed Timescale:** 29/05/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Procedures advising on management of aggression and violence required review to ensure all aspects of this area of risk were identified such as incidents of resident to resident aggression.

**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:**
The PIC and General Manager will review the Risk Management Policy to ensure the policy includes details on dealing with resident to resident aggression.

Additional procedures will be developed and implemented so as to ensure that any aggressive behaviour is documented, and reported to GP and / or Gardai if appropriate.

The PIC will brief all staff on actions to be taken in the event of an incident of resident to resident aggression

The PIC will seek out relevant training in respect of handling aggressive individuals

**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 infection prevention and control policy was under review at the time of inspection. The draft document did not reference advisory procedures to inform management of an infection outbreak.

**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:**
The PIC is currently reviewing the infection control policy, with a view to incorporating actions to be taken in the event of an infection outbreak.

THE PIC will brief all staff on the revised policy and additional steps to be taken.

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

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<th>Outcome 09: Medication Management</th>
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<td><strong>Theme:</strong></td>
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<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<td><strong>Action Required:</strong></td>
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<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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Proposed Timescale: 30/06/2015

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:
Quarterly notifications did not include details of PRN (as required) chemical restraint used.

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:
The PIC has now provided the relevant notification as required.

Proposed Timescale: 29/05/2015

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:
Review of this document was required to ensure the appeal procedure was clear where satisfaction with the outcome of internal investigation was not obtained.

Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
The Providers Nominee has reviewed the Complaints Procedure in conjunction with the PIC and General Manager.

The Complaints Procedure has been amended to fully reflect the requirements of Regulation 34 (1).

The required relevant parties have been identified and included in the revised procedure.
Proposed Timescale: 29/05/2015

**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:**
Documentation recorded attendance and did not comprehensively inform level of participation in activities or positive outcomes in meeting the individual interests of residents.

**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:**
The PIC and Deputy PIC and Activities Coordinator have undertaken a review of all resident’s likes and dislikes. This was completed in March.

A new summary of resident’s participation and level of interest is prepared and documented twice daily.

A weekly summary is present in each resident’s chart.

Residents are reassessed 4 monthly or as required to see if interests have changed.

The Activities Coordinator has completed a Sonas training course and introduced Sonas therapy for residents with Dementia.

In addition the Activities Coordinator has recently completed another course on exercise activities for the elderly and has begun to introduce same as appropriate.

The activities coordinator is researching continuously to provide new sources of stimulation and enjoyment for residents.

Proposed Timescale:

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Evidence found in relation to times of resident falls indicated that review of staffing
levels/skill mix was required to ensure residents needs were met between 20:00hrs and 02:00hrs.

This finding also requires review to ensure adequate staffing resources can be provided in terms of the provider’s application to increase resident occupancy from 22 to 30 residents.

**Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
The PIC has examined the incidence of falls at particular times.

In the past 3 months there have been no falls, this is attributed to the fact that one resident prone to falls is no longer in the home.

Having reviewed the incidence of falls the staff mix has been reviewed and was found to be appropriate.

An additional staff member has been added to the team for the night time duties when resident mix and numbers demand same.

Ongoing measures to manage falls include, ½ hourly documented checks, rearrangement of bedroom furniture to suit resident, enhanced lighting if necessary, alarm mats at bedside, GP medication review, Occupational Therapist review, Physiotherapist review, and a “safe shoes” review.

Bedrails are used only where appropriate for a resident based on a risk assessment of the risk versus the benefit in line with the National Policy on the use of restraints particularly where residents are considered to be at higher risk of falling.

Four staff members will be updated in training of protection of vulnerable persons.

Any staff member’s certificate of manual handling which is outdated will be renewed.

Further staff have been identified, interviewed and vetted in preparation for additional resident numbers. This will be an ongoing process relating to resident dependencies, needs and skill mixes required.

**Proposed Timescale:** 12/06/2015

**Theme:** Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training records confirmed that all staff had not attended training on protection of vulnerable persons and moving and handling training.

**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:**
The PIC has reviewed training records.

Four staff members will be updated in training of protection of vulnerable persons.

Any staff member’s certificate of manual handling which is outdated will be renewed.

**Proposed Timescale:** 30/08/2015