<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Valentia House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004370</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Camolin, Enniscorthy, Wexford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>053 938 3125</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:valentianursing@eircom.net">valentianursing@eircom.net</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>Valentia Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Kieran &amp; Nora Hogan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Kieran Murphy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>39</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>9</td>
</tr>
</tbody>
</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 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 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>
</tr>
</thead>
<tbody>
<tr>
<td>29 October 2014 11:00</td>
<td>29 October 2014 18:00</td>
</tr>
<tr>
<td>30 October 2014 08:00</td>
<td>30 October 2014 15:30</td>
</tr>
</tbody>
</table>

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**

Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

A number of questionnaires from residents and relatives were received prior to and following the inspection and the inspectors spoke to many residents and relatives during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided. Family involvement was encouraged with relatives and relatives stating they are welcomed at any time. Residents’ comments are found throughout the report.
Since the last inspection there had been a change in the overall governance structure. While the provider nominee remained the same, two new members had been added to the board of directors. A new schedule of management meetings was to be agreed to ensure the new board of directors was adequately monitoring the quality of care and experience of residents.

Following the inspection the provider submitted a request to the Authority to reduce the capacity from 48 to 47 beds. An amended statement of purpose was submitted to reflect the new capacity.

Inspectors saw good practice in relation to care planning and in particular for residents with identified communication deficits. There was also good practice in relation to activities care planning.

Improvements were required in a number of areas including:
- Records management
- hazard identification
- infection control
- knowledge and skills in relation to the management of behaviour that is challenging
- medication management
- notification of incidents to the Authority
- updating of care plans
- complaints management.

The Action Plan at the end of this report identifies where improvements were needed.
**Outcome 01: Statement of Purpose**

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose and function was viewed by the inspectors, and it clearly described the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre’s registration under Section 50 of the Health Act 2007 and were found to meet the requirements of legislation.

The statement of purpose outlined that accommodation was provided for 48 residents. One of the bedrooms was a three-bedded room. During the inspection the person in charge outlined this bedroom was to be reduced to a two-bedded room. Subsequently the provider submitted a request to the Authority to reduce the capacity from 48 to 47 beds. An amended statement of purpose was also submitted to reflect the new capacity.

**Judgment:**
Compliant

---

**Outcome 02: Governance and Management**

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

**Theme:**
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There had been two management meetings in 2014 with attendance by the person in charge, the provider nominee and the office manager. Since the last inspection there had been a change in the overall governance structure. While the provider nominee remained the same, two new members had been added to the board of directors. It was outlined to inspectors that the management meetings would continue. A new schedule was to be agreed to ensure the new board of directors was adequately monitoring the quality of care and experience of residents.

There was a policy on quality assurance and continuous improvement available. The person in charge had introduced a system of quality assurance reviews which included audit of healthcare documentation, infection control, resident care plans, incidents and staff files. The results of the audits were available with actions identified to remedy deficits. However, there was no formal annual review of the quality and safety of care delivered to residents as required by Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (the regulations).

The person in charge had a process of seeking formal feedback from residents and a satisfaction survey had been distributed in 2014. The person in charge had reviewed all the issues identified and all residents and families that spoke with the inspectors were satisfied with the care provided.

Judgment:
Non Compliant - Major

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
A number of contracts of care were viewed by the inspectors. The contracts of care were found to be comprehensive and were agreed and signed within a month of admission. The contracts stipulated the services to be provided and the fees included in the contract.

There was an up to date policy on the management of fees and other expenses. Additional services provided, for example chiropody, newspaper, physiotherapy and
hairdressing were outlined in the contract. The fees for all these services were taken from the resident’s day to day expenses. Inspectors reviewed the system in place to safeguard resident’s finances. While summary statements of spending were not made available at regular intervals to the resident or their families, the expenses were signed for at each transaction by either the resident or their representative and countersigned by two staff members.

There was a policy on the provision of information to a resident which included the residents’ guide. This guide was compliant with the regulations as it contained a summary of services and facilities, the terms and conditions of admission, a summary of the complaints process and the arrangements for visits.

**Judgment:**
Compliant

---

**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge was a registered general nurse since 1996 and had been director of nursing since 1999. She had engaged in continuing professional development including attendance at courses in palliative care, medication management and infection control. Residents with whom inspectors spoke were clear in their understanding of the role of the person in charge and commented that she was available at all times. The inspectors were satisfied that the person in charge was engaged in the governance, operational management and administration of this centre on a regular and consistent basis.

**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:**
Inspectors viewed the insurance policy and saw that the centre was adequately insured against accidents or injury to residents, staff and visitors.

The directory of residents was found not to contain details in relation to resident transfer to hospital or the date of transfer as required by schedule 3 of the regulations. In addition the directory of residents did not include details of the cause of death of residents as required by the regulations.

Inspectors found that the medical and nursing records were comprehensive. The care plans and the record of care provided to residents were accurately documented. However, the mechanisms in place for managing residents’ healthcare records required improvement. In particular the records of review by GP, consultants and allied health professionals were filed in plastic pockets towards the back of the healthcare record. This system did not adequately ensure that relevant information was accessible to staff to inform the care planning for residents.

There was a policy on staff recruitment and selection which outlined that no appointment was to be finalised until satisfactory references had been received. Inspectors reviewed a sample of staff files and found that references for one staff member had not been verified until five months after they had started employment. This issue had been identified also by the office manager in an audit of staff files in May 2014.

There was also evidence that while records were being kept, they were not being filed appropriately. For example the daily inspection of fire exits was kept in a separate book in the nurses' office and not in the fire register with the rest of the fire documentation. As on the previous inspection it was found that one complaint had been filed inappropriately in a staff personnel file.

**Judgment:**
Non Compliant - Minor

---

**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.
### Governance, Leadership and Management

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
</tr>
</tbody>
</table>

**Findings:**
There had not been any period where the person in charge was absent for 28 days or more since the last inspection. The person in charge and the nominated registered provider were aware of the obligation to inform the Chief Inspector if there was any proposed absence of the person in charge.

There were clear arrangements to cover for the absence of the person in charge. The assistant director of nursing had responsibility for management of the centre when the person in charge was absent. She was a registered general nurse and had worked in the centre since 2005. While she wasn’t present during the inspection, based on her qualifications and experience the inspectors were satisfied that the assistant director of nursing had the requisite skills and experience in care of the older person to deputise for the person in charge.

**Judgment:**
Compliant

### Outcome 07: Safeguarding and Safety

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

**Theme:**
Safe care and support

<table>
<thead>
<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
</tr>
</tbody>
</table>

**Findings:**
There were a number of policies available on safeguarding and safety including:
- Protection of resident from abuse
- responding to allegations of abuse
- responding to allegations of abuse perpetrated by a resident
- responding to allegations of abuse perpetrated by a service provider or person in charge or staff.

All staff had received in-house training on the protection of vulnerable adults. Since the last inspection there had been one incident of an allegation of verbal abuse of a resident. The inspector was satisfied that this matter had been dealt with appropriately by the person in charge.
There was a policy on meeting the needs of residents with challenging behaviour. An audit of challenging behaviour had been undertaken in August 2014 by the person in charge. The person in charge was not satisfied that one incident had been managed appropriately by staff and identified a deficit in staff knowledge and skills. Training for all staff on challenging behaviour had since been organised but had not yet taken place.

There was a policy on the use of restraint and a policy on the use of bed rails. The restraint register contained an evidence based rationale for the use of the restraint in each case. The register was signed by the resident/representative and the person in charge. Inspectors saw that residents had an individual restraint assessment form available in their healthcare file. The restraints register indicated that 15 residents were using bed rails at night. Five residents, who had been assessed as being at risk of absconding, had a security tag in place. There was monitoring of the resident while the restraint was in place and this was recorded in the healthcare file. One resident was using a specifically fitted wheelchair which had been prescribed and assessed by an occupational therapist for the resident to maintain posture. This chair did restrict the resident’s mobility by use of a table and restraining belt but it was recorded appropriately on the restraint register.

Judgment:
Non Compliant - Major

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

Theme:
Safe care and support

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

**Findings:**
The risk management policy was up to date and contained the measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm.

There was an incident reporting policy and records indicated that there had been no reported incident from December 2013 to May 2014. Since May there had been 13 reported incidents all of which involved residents falling. While the incident reporting policy indicated that each incident was to be rated according to a severity scale of low/moderate/high, this was not completed for any of the incidents recorded. The incident reporting policy also outlined that resident falls were to be recorded both in the resident notes and the accident report book. An audit of incidents undertaken by the person in charge identified that in some cases the healthcare notes did not refer to the resident fall and any subsequent nursing or medical intervention.
There was an organisation safety statement which outlined arrangements for issues like moving and handling and residents absconding. However, risk assessments were not available for:

- Latex gloves available in boxes in the corridor
- Disposable aprons being available in the corridor
- Disinfectant bottles being accessible in bathrooms
- Potential trip hazard from the carpet in the corridor leading to the fire exit on the first floor.

At the last inspection there had been a number of actions identified in relation to cleaning practices and the inspectors found that these had been adequately addressed. There was a cleaning policy and the centre was visibly clean with a cleaning schedule identifying areas to be cleaned and cleaning frequencies.

There was an infection control policy. Hand washing facilities were located in the main entrance lobby, and wall mounted alcohol hand gel was available throughout the centre. Household staff were knowledgeable in the area of infection control. However, inspectors were informed that the mop heads were used to clean multiple bathrooms without being changed which could lead to potential cross contamination. There was a policy on the management of clostridium difficile infection and cleaning staff were aware of how to clean the room of any resident with this infection.

Inspectors visited the laundry room where staff were aware of infection control principles and in particular the need for separate storage of dirty clothes, washed clothes and clean clothes. The inspectors observed only one entrance/exit into the laundry and clean items was brought from the laundry past dirty items which was not safeguarding control of infection in the management of laundry.

There was a valid fire certificate for the centre dated 20 July 2014. Inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:

- Servicing of fire alarm system and alarm panel October 2014
- Fire extinguisher servicing and inspection February 2014.

In relation to fire safety, the provider outlined that the centre was divided into separate fire resisting compartments. In the event of a fire the plan was for residents to be moved from the compartment involved in the fire to the adjacent compartment and if necessary moved again. These compartments were accessed via fire doors. Certification was available for the installation in October 2014 of 22 magnetic door holders in residents’ bedrooms which automatically released when the fire alarm sounded. However, inspectors observed the fire door to the kitchen wedged open with a wooden wedge and the fire door to the main living room being wedged open with an armchair.

All staff had been trained in fire safety within the last year and there had been fire and evacuation drills with the most recent completed in June 2014. There was daily recording of inspection of means of escape routes and monthly recording of inspection of emergency lighting. This issue is identified in Outcome 5 in relation to management of records.
There was a smoking policy which identified that residents could only smoke outside the building. In practice the smoking area was in the internal courtyard and the person in charge outlined that any resident, while smoking, was supervised in this area by staff. However, inspectors observed that fire precautions weren’t available in this area.

There were three emergency plans available:
• Emergency plan in relation to fire (undated)
• the management of internal emergencies including resident absconding and fire evacuation May 2014
• an emergency plan, dated September 2014, addressing the centre’s response to fire and other emergencies like loss of power, loss of heating or water supply. It also included the accommodation arrangements to be implemented in the event of an evacuation.

There was a personal emergency evacuation plan for each resident but none were signed or dated.

**Judgment:**
Non Compliant - Major

---

**Outcome 09: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

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

**Findings:**
The centre-specific policy on medication management was made available to the inspectors. The policy was comprehensive and evidence based.

The previous inspection had identified a number of actions in relation to transcription of prescriptions. On this inspection each transcription record had been signed by the transcribing nurse, checked by a second nurse and co-signed by the prescribing doctor within a designated timeframe. In the sample healthcare files seen by inspectors each resident had their medication reviewed by their general practitioner (GP) at least every three months. However, in the sample prescription sheets reviewed by inspectors it was not clear that a record of each drug and medication was signed and dated by the GP. The signature of the GP was not in place for each drug prescribed in the sample of drug charts examined.

A number of residents’ prescription records contained a general direction that the resident required medication to be given in a modified form to that prescribed (i.e.
crushing an oral medication that is in a tablet or pill form). Each medication when administered in a crushed format is outside its licensed conditions. Inspectors saw that the prescription record contained a general instruction that the medications for that resident were to be crushed rather than each individual medication being prescribed as crushed.

Inspectors saw evidence that a pharmacist was available to residents on a regular basis and had arranged a meeting to talk with residents in October 2014. Medication for each resident was dispensed by pharmacy on a weekly basis. The dispensed medication was checked by the person in charge and stored in either the locked medication trolley or a locked cabinet. A separate, secure and dedicated refrigerator was available for medicines that required storage between 2°C – 8°C. However, the inspectors observed that the temperature of the medication refrigerator was not monitored and so the centre could not ensure that medications requiring refrigeration were stored in the appropriate environment, contrary to professional guidance issued by An Bord Altranais agus Cnámhseachais (Bord Altranais).

During the medication administration round inspectors found that appropriate checks were undertaken by nursing staff to ensure the right medication was administered to the correct resident at the correct time. However, nursing staff indicated that while some medications were prescribed for 07:00 hrs, not all residents would receive their medications at the prescribed time, with some residents not receiving it until they awoke some time later in the morning. This practice was not in accordance with professional guidance issued by Bord Altranais.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. Medication management training was facilitated regularly and the nurses spoken with displayed a good knowledge of medications and the procedure outlined for administration.

Since the last inspection the procedure had been improved for the returning of unused or discontinued medication to pharmacy. The pharmacist now came, received the unused medication and then dispensed a revised medication pack for the resident.

The person in charge had recently completed a medication management audit on identified issues like prescriptions, return of medication to pharmacy, transcriptions and photographic identification of residents.

**Judgment:**
Non Compliant - Major

**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:
It is a requirement of the regulations that all serious adverse incidents are reported to the Authority. While a record of all incidents occurring had been maintained, a notification of the allegation of verbal abuse of a resident had not been sent to the Authority.

Judgment:
Non Compliant - Major

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

Theme:
Effective care and support

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

Findings:
There was evidence that each resident was assessed on admission for issues including communication, recreation, maintaining a safe environment, mobility, temperature, hygiene, nutrition and dying. Each resident had their weight and a malnutrition universal screening tool (MUST) outcome measure recorded on admission and monthly thereafter.

In the sample of care plans seen the assessments on admission informed the care planning process. In particular inspectors saw that care plans were developed in conjunction with evidence based assessments of resident’s needs in relation to issues like wound care, dependency levels and pressure sore development. There was evidence that the resident and their families were involved in the development of care plans. However, in the sample healthcare files reviewed inspectors saw that some nursing care plans had not been updated, for example following a change in a resident's nutrition requirements by the dietician.

Inspectors saw evidence that residents’ health care needs were met through timely access to general practitioner (GP) services. Residents had the option of care from their own GP and there was evidence of a review of each resident's health and medication at least once every three months.
Healthcare records reviewed indicated that residents had appropriate access to allied health care services. A number of residents had nutrition care plans recommended by a dietician. Inspectors saw evidence of care planning for residents requiring percutaneous endoscopic gastrostomy (PEG or directly into the stomach) feeding with appropriate supervision provided by the dietician. Inspectors saw evidence of appropriate referral to and review by speech and language therapists with swallow care plans prepared for residents as required. All staff had received training in nutrition and dysphagia (swallowing difficulties) in September 2014.

As mentioned in Outcome 7 some residents had been assessed by an occupational therapist in relating to seating. In the occupational therapy plans seen there was evidence of close liaison with the resident’s GP in relation to seating.

There was evidence of good communication links between the centre and the acute general hospital when residents required review and treatment by consultant specialists. The healthcare record included summaries of medical reviews from specialists in acute care hospitals. The person in charge outlined that when residents were transferred to acute care a copy was included of the resident’s up to date medication list, copy of the GP transfer letter and a copy of the nursing transfer letter. However, inspectors could not verify this as the transfer information was not maintained in the resident’s healthcare file.

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

**Findings:**
The centre was designed and laid out to meet the needs of 48 residents. As outlined in Outcome 1 this was reduced to 47 residents following the inspection.

The provider had undertaken an audit of rooms in May 2014 and identified that two bedrooms needed to be extended in 2015 to meet the specifications set out in criteria 25.39 and 25.40 of the National Standards for Residential Care Settings for Older People in Ireland 2009 (the Standards). The provider is to submit plans to the Authority in relation to these extensions prior to commencement of works.
Having regard to the number of residents there was sufficient number of toilets, wash basins, baths and showers. The ground floor contained two shower rooms with a toilet and wash-hand basin, an assisted bathroom with a toilet and wash-hand basin and a disused bathroom currently being used for storage purposes. On the first floor there were two bathrooms, one of which contained a bath, wash-hand basin and toilet and the second had a shower, a toilet and wash-hand basin. There were appropriate sluicing facilities available.

There was a separate kitchen which had suitable and sufficient cooking facilities. Communal facilities comprised a sitting room, a conservatory, a library, an oratory and a spacious cafeteria which was used at times for resident birthday parties and funeral removals. There were mature and well maintained gardens externally and a well designed internal courtyard which was accessible to residents.

There was appropriate assistive equipment available and stored conveniently to meet the needs of residents, such as electric profiling beds, hoists, pressure-relieving mattresses and cushions, wheelchairs and walking frames. Inspectors observed residents moving around independently on corridors which had hand-rails that promoted independence. Since the last inspection the chairlift between the first and second floors had been serviced in July 2014.

**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:**
There was a complaints policy, a copy of which was displayed in each resident’s bedroom. However the inspectors found that the policy did not contain provision for recording of the outcome of the complaint and whether the complainant was satisfied or not.

Inspectors reviewed the complaints log and found that there had been four recorded complaints since the last inspection. As on the previous inspection it was found that one complaint had been filed inappropriately in a staff record. This is discussed earlier in this report in Outcome 5 relating to records management. In addition the complaints log didn’t contain evidence that the complainant’s satisfaction with the outcome of the complaint investigation was being recorded.
Judgment:
Non Compliant - Minor

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:
The centre had participated in a national initiative by the Authority, the purpose of which was to assess compliance with the specific themes of end of life care and nutrition. The centre had assessed itself as being non-compliant with the regulations and standards in relation to end of life care because each resident did not have an end of life care plan at the time of submission of the self assessment. However, during inspection all the healthcare files seen did contain end of life care plans and the centre was compliant.

There was an end of life care policy and there was evidence that residents on admission had their spiritual needs and wishes for dying recorded. Care plans seen by the inspectors identified spiritual and end of life care needs of residents and, where appropriate, recorded discussions with the resident and their family around cardiopulmonary resuscitation (CPR). In the healthcare records reviewed there was evidence of appropriate assessment, review and support of residents at end of life by the GP.

There was a large oratory with religious services being held regularly. If the resident wished, the centre facilitated a prayer and removal service in the centre. Following a resident’s death their property was stored and returned to the family as appropriate.

The person in charge indicated that single en-suite rooms were made available for residents at end of life. There was unrestricted access for families with showering and dining facilities also being made available.

There was evidence in the care plans seen that discussions had taken place with the resident as to whether they wished to be transferred to an acute care hospital in the event of a deterioration of their condition.

Records seen by the inspector showed following a resident’s death arrangements were in place for contacting:
• Family
• medical officer
• undertaker.

Documentation submitted to the authority outlined that three nurses had attended a course on palliative care and a number of other staff had received training on the end of life care. The person in charge outlined that further training on end of life care was planned.

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:

In relation to food and nutrition the centre had assessed itself as non-compliant during the national self assessment on food and nutrition undertaken by the Authority. This was due to an identified training need in relation to nutrition at the time of self assessment. However, as this had since been rectified, the inspectors found the centre to be compliant with this outcome.

There was a policy on the monitoring and documentation of nutrition. Nutrition care plans from the dietician and swallow care plans from the speech and language therapist were available in residents’ healthcare files. They were also communicated to the catering staff who maintained a copy of each resident’s dietary requirements. Catering staff spoken with were able to articulate each resident’s nutritional needs.

There was a menu plan available on a three weekly cycle which offered good choice at all meals. Catering staff outlined that the nutritional value of the meals was assessed regularly by a dietician. As an example of good practice inspectors saw evidence that individual care plans had been agreed with some residents around choice at meals and mealtimes. Actions included arranging for the resident to talk to catering staff regarding their likes and dislikes.

Breakfast was served from 07:00 hrs, lunch from 12 mid-day and evening tea was from 17:00 hrs to 18.30 hrs. There were two spacious dining areas, the smaller of which catered for residents who required more assistance at mealtimes. Residents could also choose to dine in their own room if they wished. There was sufficient staff available to offer assistance at mealtimes and inspectors observed a pleasant dining experience. There was access to fluids and snacks throughout the day and tea trolleys were seen in
circulation during the morning and afternoon. Residents outlined to inspectors that they were satisfied with the variety and quality of food served.

The most recent Environmental Health Officer report was available. The inspectors saw documentation that all catering staff had received food hygiene (HACCP) training in February 2014.

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

**Findings:**
Inspectors saw evidence that residents were consulted about how the centre was planned and run. There was a residents committee which met every six months. The minutes were available from the last meeting which was attended by 21 residents. Issues discussed included laundry, call bells, menu planning and excursions. There was an annual resident survey and the person in charge outlined that all issues raised in the survey had been acted upon. There was a quarterly newsletter with items of interest to residents including reviews of social outings.

There was a full time activities coordinator with a schedule of activities including sing-a-long, exercise programmes and reminiscence therapy. One-to-one activities were also facilitated. As an example of good practice inspectors saw recreation care plans in residents healthcare files with activities personalised to the interests of the resident. The centre had organised a number of day trips during the summer including an outing to a nearby holiday resort.

Each resident’s communication ability was assessed on admission. Based on this assessment, if required, communication care plans were in place. There was evidence of appropriate referral to speech and language therapists and the development of programmes for residents to help them communicate. Inspectors also saw that residents were being reviewed as necessary by consultant specialists.

There was an open visiting policy and families with whom inspectors spoke confirmed that there were no restrictions on visits. There were a number of areas throughout the
centre where each resident could receive visitors in private.

Judgment:
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 inspectors reviewed a policy on security and building access which outlined the arrangements in place for residents to retain control over their own possessions and clothing by means of lockable storage in the room.

The laundry staff adequately explained the process in place to ensure clothes were returned to the resident. The residents’ committee had raised issues in relation to clothes going missing. The person in charge said that all these issues had been followed up.

Inspectors saw personalised living arrangements in resident’s rooms with photographs and personal effects.

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):
No actions were required from the previous inspection.

**Findings:**
Based on the review of the staff rota, inspectors were satisfied that there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times. Staff included at least one staff nurse at all times.

As outlined in Outcome 5 improvements were required in relation to effective recruitment procedures and in particular appropriate reference checking.

There was a staff performance review undertaken annually by the person in charge which gave an opportunity to staff to discuss their role and also to discuss personal objectives and personal developments plans including further education. Staff confirmed to inspectors that they had been facilitated in accessing continuing professional education by the provider. There was a training programme in place and all staff had received mandatory training as required by the regulations. However, as outlined in Outcome 7 training for all staff on challenging behavior was scheduled for November 2014.

The person in charge outlined that there were no people involved on a voluntary basis with the centre.

**Judgment:**
Compliant

**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:**

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Valentia House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0004370</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>29/10/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29/01/2015</td>
</tr>
</tbody>
</table>

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:
There was no formal annual review of the quality and safety of care delivered to residents.

Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
A full review of the Quality & Safety of care has taken place in January 2015- please see attached report. This report has been made available to the residents and or their representative. All issues communicated to staff at meeting on 28th January.

Proposed Timescale: 29/01/2015

Outcome 05: Documentation to be kept at a designated centre
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents was found not to contain details in relation to resident transfer to hospital or the date of transfer.

Action Required:
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:
Directory of residents has been changed from a manual hardback book to an electronic spreadsheet. Separate spreadsheets now contain information on hospital transfers, reason for transfer & length of stay.

Proposed Timescale: 31/01/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not include details of the cause of death of residents.

Action Required:
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

Please state the actions you have taken or are planning to take:
Directory of residents has been changed from a manual hardback book to an electronic spreadsheet and now contains information on the cause of death of deceased residents. Separate spreadsheets now contain information on hospital transfers, reason
<table>
<thead>
<tr>
<th>Proposed Timescale: 31/01/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Governance, Leadership and Management</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
References for some staff had not been verified until five months after they had started employment.

**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 above has already been identified in the audit and addressed with administration. New management will ensure references for new staff are checked prior to employment commencing.

<table>
<thead>
<tr>
<th>Proposed Timescale: 29/01/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Governance, Leadership and Management</td>
</tr>
</tbody>
</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was evidence that while records were being kept, they were not being filed appropriately.

**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:**
Records have been re formatted to ensure all health and allied health information is accessible.

<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme: Governance, Leadership and Management</td>
</tr>
</tbody>
</table>
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
This filing of information in healthcare records did not adequately ensure that relevant information was accessible to staff to inform the care planning for residents.

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 have been re formatted to ensure all nursing, medical and allied health information is available to inform systematic and comprehensive care needs assessment and care planning.

Proposed Timescale: 29/01/2015

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a deficit in staff knowledge and skills in relation to the management of behaviour that is challenging.

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

Please state the actions you have taken or are planning to take:
Training in responsive behaviours has taken place in November and December 2014 and to date 19 staff have completed the training. The person in charge has just completed Person Centred Dementia Care NS466 module in DCU and is now part of the national Dementia Champion network. Further training in responsive behaviour will be rolled out by the PIC in 2015. A timetable for same will be finalised as soon as certification of the module is received from DCU. The PIC will provide ongoing support to all staff to ensure person centred care and appropriate management of responsive behaviours.

Proposed Timescale: 04/12/2014

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:
Risk assessments were not available for:
• Latex gloves available in boxes in the corridor
• Disposable aprons being available in the corridor
• Disinfectant bottles being accessible in bathrooms
• Potential trip hazard from the carpet in the corridor leading to the fire exit on the first floor.

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

Please state the actions you have taken or are planning to take:
Risk assessments were carried out on all of the above on 28th November 2014.

Storage unit have been erected in three places in the nursing home to accommodate safe storage of and access to personal protective equipment.

Carpet has been removed and replaced by non-slip flooring leading to the fire exit on the first floor.

The disinfectant in use in the bathroom has been reviewed and changed to a cleaning product. The storage of this in the bathrooms has been risk assessed and rated as a safe and manageable risk at present. This will be reviewed if the profile of any of the residents changes.

Proposed Timescale: 29/12/2014
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements for the identification and recording of incidents required improvement as incidents were not rated according to severity.

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

Please state the actions you have taken or are planning to take:
Documenting and recording of incidents has changed. A new incident form has been developed and all incidents are being logged electronically. An incident severity rating has been added to the form. All staff with responsibility for recording incidents have
been shown and instructed how to use the form.

**Proposed Timescale:** 29/01/2015  
**Theme:**  
Safe care and support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Mop heads were used to clean multiple bathrooms without being changed which could lead to potential cross contamination.

**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:**  
New mop head system has been introduced that eliminates the risk of potential cross contamination between bathrooms. Housekeeping staff have been instructed on the system and the potential infection control risk has been highlighted with them.

---

**Proposed Timescale:** 29/01/2015  
**Theme:**  
Safe care and support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was only one entrance/exit into the laundry and clean items was brought from the laundry past dirty items which was not safeguarding control of infection in the management of laundry.

**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:**  
As there is only one entrance/exit to the laundry the risk above has been eliminated by storing the linen skip containing unwashed items to the right of the laundry door as you exit. Staff have to turn left to return clean linen to the nursing home, therefore do not come in contact or pass the linen skip as they return clean linen to individual wardrobes.
Proposed Timescale: 29/01/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The fire door to the kitchen was kept open with a wooden wedge and the fire door to the main living room was wedged open with an armchair.

Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
1) Door to living room no longer wedged open with an armchair all staff aware.
2) Risk assessment completed on 28/11/2014 in respect of the kitchen doors being wedged open at meal times only. **Magnetic locks were due to be fitted on doors by 30th January 2015. There has been a delay due of unavailability of parts. The electrician and the security provider Sharp are both working together to ensure the magnetic-locks are fitted by Tuesday 3rd February.

Proposed Timescale: 03/02/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire precautions weren’t available in the smoking area.

Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
Fire extinguisher and fire blanket fitted in smoking area- There are currently no smokers residing in Valentia. Smoking risk assessments will be carried out on any resident who chooses to smoke.

Proposed Timescale: 30/01/2015

Outcome 09: Medication Management

Theme:
Safe care and support
<table>
<thead>
<tr>
<th>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The signature of the GP was not in place for each drug prescribed in the sample of drug charts examined.</td>
</tr>
</tbody>
</table>

**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:**
Relevant GP has been made aware of the above and same has been addressed.

---

**Proposed Timescale:** 29/01/2015

**Theme:**
Safe care and support

<table>
<thead>
<tr>
<th>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The prescription record contained a general instruction that the medications for that resident were to be crushed rather than each individual medication being prescribed as crushed.</td>
</tr>
</tbody>
</table>

**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:**
Instructions for individual crushed medications have been reviewed on 3rd and 4th December 2014. As an interim measure all residents that require crushed medications will have same documented on the existing kardex by the GP.
It was decided to introduce a new medication prescription kardex system into the nursing home with a timeframe for completion end of April 2015. This will be done in consultation with the pharmacist. To date there have been two meetings with the pharmacist.

---

**Proposed Timescale:** 31/01/2015

**Theme:**
Safe care and support

| The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect: |
Medications not administered at the prescribed time.

**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:**
The above has been addressed with all nursing staff and medications are administered at prescribed times.

**Proposed Timescale:** 29/01/2015
**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The temperature of the medication refrigerator was not monitored and so the centre could not ensure that medications requiring refrigeration were stored in the appropriate environment.

**Action Required:**
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

**Please state the actions you have taken or are planning to take:**
Fridge thermometer and check list in place.

**Proposed Timescale:** 29/01/2015

**Outcome 10: Notification of Incidents**

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A notification of the allegation of verbal abuse of a resident had not been submitted to the Authority within timeframe specified in regulation 31(1).

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

Above notification submitted to HIQA retrospectively. New management will ensure that future notifications will be managed according to HIQA requirements and submitted within the timeframes set down.

Proposed Timescale: 31/01/2015

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

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

Care plans not kept updated following review by allied health professionals.

Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
Care plans are updated on an ongoing basis to reflect any changes to a resident's care by allied health professionals, GP, Nurse and any change in the resident's need. A new system of variance care planning will be introduced on a phased basis to all care plans. New admission will be commenced immediately on the new variance care planning. Existing care plans will be converted during the coming months at the four monthly care plan review.

Proposed Timescale: 29/01/2015

Theme:
Effective care and support

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

Resident's transfer information to hospital was not available for review.

Action Required:
Under Regulation 25(1) you are required to: Provide all relevant information about each resident who is temporarily absent from the designated centre for treatment at another designated centre, hospital or elsewhere, to the receiving designated centre, hospital or place.

Please state the actions you have taken or are planning to take:
Photocopies of all transfer documentation are being retained in resident files.
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 nominated person wasn’t maintaining a record of all complaints including details of any investigation into the complaint, the outcome of the compliant and whether or not the resident was satisfied.

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

Please state the actions you have taken or are planning to take:
A new Complaints book has been drafted and is available to the residents and family/care representative. Information on the following will be recorded; Date & time, Name of person making complaint, Details/nature of complaint, Action plan, Outcome and Satisfaction with outcome. All complaints will be electronically logged and reviewed on an ongoing basis.

Proposed Timescale: 29/01/2015

Proposed Timescale: 30/01/2015