Health Information and Quality Authority
Regulation Directorate

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

Centre name:	Summerville Healthcare
Centre ID:	OSV-0000397
Centre address:	Strandhill, Sligo.
Telephone number:	071 912 8430
Email address:	info@summervillehealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Summerville Healthcare Limited
Provider Nominee:	Mary Gilmartin
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	46
Number of vacancies on the date of inspection:	0

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
21 July 2015 10:30	21 July 2015 20:40

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report set out the findings of an unannounced monitoring inspection. This inspection took place over one day. The inspector reviewed progress on the action plan from the previous inspection carried out in May 2014. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

A new person in charge has been appointed the last inspection. The person appointed fulfils the criteria required by the Regulations in terms of appropriate qualifications and management experience.

The inspector found that residents were receiving responsive healthcare that met their assessed needs. There was evidence of individual residents' needs being met. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access.

The physical environment meets the needs of residents. A new well designed safe enclosed garden has been provided. A range of activities were provided that people

could choose to take part in.

A total of ten Outcomes were inspected. The inspector found two Outcomes as moderately non compliant. These included, Health and Social Care Needs and Safeguarding and Safety. Five Outcomes were judged as compliant with the Regulations and a further three as substantially in compliance with the Regulations.

The areas of moderate non compliance primarily related to;

Practice on promoting a restraint free environment was not fully reflective of the national policy.
There was not a system developed to ensure residents with a do not resuscitate (DNR) status had the status regularly reviewed.

The action plan at the end of this report identifies these and other areas where improvements 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 (as amended) 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:
The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider and had been updated in December 2014.

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:
The inspector found that the management structure was appropriate to the size, ethos,

and purpose and function of the centre. There was an organisational structure in place to support the person in charge. The provider attends the centre routinely.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge. Clinical data was collected and reviewed weekly. This included information on physical restraint management, the number of resident on psychotropic medication, wound care, accidents/incidents and any hospital admissions. The inspector found that this information was used to improve the service.

A comprehensive audit of falls by residents was undertaken. The information collected was utilised to identify trends or pattern of risk. It was identified the majority of falls occurred in the day room. As a result a staff member was rostered to the day sitting to supervise and assist residents during the day time.

An audit of the usage of psychotropic medication was undertaken. The aim of person in charge through the audit was to ensure the optimum health of residents with the reliance on the minimum amount of medication. The person in charge was working in consultation with GP's. Reports on progress at the time of this inspection were unable available as the audit was in the initial stages.

The quality assurance program reviewed practice in the management of wound care and medication systems. Action plans were developed and changes implemented to improve practice and ensure safe care.

There is a key senior manger nominated to deputise while the person in charge is absent. However, the management team indicated the deputy nominated is resigning from his post shortly. The person in charge indicated a new key senior manger will be nominated to deputise while the person in charge is absent.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that all residents had an agreed written contract. The contract of care was revised as this was an area identified for improvement on the last inspection.

The cost of additional expenses incurred by residents was set out in the revised contract of care. This identified charges payable per items not included in the overall fee.

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:
A new person in charge has been appointed the last inspection. The Authority was appropriately notified as required by the Regulations. All the necessary documentation accompanied the notification.

The person appointed fulfils the criteria required by the Regulations in terms of appropriate qualifications and management experience. The person in charge is an experienced nurse. She holds a full-time post. She was well known by residents. She had good knowledge of residents care needs. The person in charge and could describe in an informed way where residents had specific needs and how staff ensured resident's care needs were met appropriately.

There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge. As discussed in Outcome 2, Governance and Management the person in charge plans to further develop systems to review the quality and safety of care.

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:
The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies were in place to inform practice and provide guidance to staff. However, as required from the action plan of the last inspection some polices remain outstanding for review to ensure they are fully centre specific. Namely the adult protection, medication and risk management policies.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner.

A sample of five staff files to include the files of the two most recently recruited staff was reviewed. The files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

A directory of residents was maintained. The directory contained all the information required by schedule three of the regulations. However, the most recent transfer by a resident to hospital was not recorded in the directory.

Judgment:
Substantially Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Residents spoken with stated that they felt safe in the centre. There was a visitors log in place. The front door was secured. Staff to whom the inspector spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. The majority of staff had up to date refresher training in protection of vulnerable adults. An ongoing program of training in protection of vulnerable adults was in place.

Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Siochana vetting forms examined by the inspector in staff files.

No notifiable incidents of adult protection which are required to be reported to the Authority occurred since the last inspection.

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy.

The inspector reviewed a sample of assessments that underpinned physical restraint practice (bed rails). Restraint measures in place included the use of bed-rails by 21 residents. There was conflicting information between the risk assessment and care plans and the daily handover report. The care plans for two residents outlined a low bed and crash mats were in use. However, the handover report confirmed side rails were raised.

There was a risk assessment completed prior to the use of the restraint. Signed consent was obtained by the resident or their representative and the GP and the physiotherapist was involved in the decision process. However, the risk assessments were not revised at frequent intervals in line with other assessments.

Documentation and observation evidenced alternative options prior to using a restraint measures were explored. There were six sensor mats in use and two crash mats. Eleven residents were provided with an ultra low bed.

However, practice was not fully reflective of the national policy on promoting a restraint free environment. In some cases there were no details why the alternatives trialled were unsuccessful. There was no rationale detailed to outline how the raised bed-rail supported the resident and ensured an enabling function.

Training in the management of behaviour that is challenging was being completed with staff. At the time of this inspection all staff were not trained. The policy to guide staff action and intervention in responding to behaviours that challenge requires review. The model of behaviour management utilised by the centre and in which staff were being trained was not clearly defined in the policy.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The governance arrangements to manage risk situations were specified. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy.

The inspector reviewed the fire safety register and training records. Staff to whom the inspector spoke confirmed their attendance at fire training and gave accounts of their understanding of fire procedures in the event of an outbreak of fire. An ongoing program of refresher training in fire evacuation was in place and further training was planned throughout 2015. A small number of staff were identified as requiring refresher training in fire safety.

Fire safety equipment including the fire alarm, fire extinguishers, emergency lighting and smoke detectors were provided and were serviced quarterly and annually as required. The procedures to follow on hearing the alarm and action to take on discovering a fire were displayed around the building. New signage was provided as required from the action plan of the previous inspection.

Fire exits were checked daily. The fire alarm was activated routinely and automatic door closer checked. Fire extinguishers were not checked routinely to ensure they were in place and intact. Risk assessments were completed to identify the mobility needs of residents in the event of a fire. However, a review was required to ensure they were maintained up to date as residents with increased dependency needs required their evacuation plans to be updated.

Four fire drills were completed by staff in the past 12 months. However, there were no records to evidence all staff had the opportunity to participate in fire drills in addition to annual training. The fire drill records did not record the time taken for staff to respond to the alarm. The drills did not record the scenario/type of simulated practice.

There was one resident who smoked at the time of inspection. Cigarettes and lighters were held in safekeeping by staff. There was a plan of care in place. However, this required review to detail the level of supervision and assistance required by the resident.

There was a cleaning system in place to break the cycle of infection and minimise the risk of cross contamination. Separate cleaning equipment and cloths were used to clean each bedroom and communal areas.

Audits of the building were completed at intervals to ensure the centre was visibly clean. A separate cleaning and sluice room was provided. Access to both rooms was restricted in the interest of safety to residents and visitors. There were a sufficient number of cleaning staff rostered each day of the week. Staff were able to explain how they cleaned a room in the event of an outbreak of infection.

Hand testing indicated the temperature of hot water did not pose a risk of burns/scalds. Records reviewed indicated hot water outlets were flushed regularly to minimise the risk of Legionella.

There was sufficient moving and handling equipment available to staff to meet residents needs. A contract was in place for servicing of equipment to include breakdown and repairs of equipment. Each resident's moving and handling needs were identified and available to staff at the point of care delivery in bedrooms. These outlined whether a resident required the assistance of a hoist or one or two staff members. There was an ongoing program of refresher training in safe moving and handling of residents.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Record sheets were available to record neurological observations where a resident sustained an unwitnessed fall or a head injury.

A new enclosed garden has been provided for use by residents. This was an area identified for improvement in previous inspections.

Judgment:
Substantially Compliant

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 in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident.

Each resident's medication was dispensed blister packs. The blister packs on arrival were

checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident.

Medications are not transcribed. At the time of this inspection the person in charge was trialling the use of new medication kardex's. A small number of the new types of kardex's were being use as a pilot study. The kardex's were printed and legible. However, they did have a column to identify drugs which require crushing or space to record the max dose for PRN (as required medication).

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medicines were being stored safely and securely in the clinic room which was secured. Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations.

Nurses kept a register of controlled drugs. Controlled drugs were checked at the change of each shift. There was two signatures in place each time the drugs were checked at the change of shift. The inspector checked a selection of the balances and found them to be correct.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
There were 46 residents in the centre during the inspection. There were 13 residents with maximum care needs. Twelve residents were assessed as highly dependent and 11 with medium dependency care needs. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

The arrangements to meet residents' assessed needs were set out in individual care

plans. The inspector found a good standard of care and appropriate medical and allied health care access. There was a good emphasis on personal care and ensuring personal wishes and needs were met. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments.

The inspector reviewed three resident's care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, a wound problem, potential behaviour that challenges and residents at high risk of falls and with bedrails raised.

Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector. There was documentary evidence that residents or their representative were involved in the development and review of their care plan.

Care plans for residents with dementia or behaviours that challenge required review to ensure they are more person centred. In some instances the inspector found that while the degree of confusion was outlined for example "severe cognitive decline" there was no information that indicated how this impacted on daily life. Information such as who the resident still recognised or what activities could still be undertaken which guide staff practice was not always evident. Other plans of care to meet the psychosocial needs of residents require review to ensure they are person centred and linked to the resident's life history.

Residents had access to GP services and there was evidence of medical reviews frequently. It was evidenced in medical files new residents were seen by the GP within a short timeframe of admission. The consultant psychiatrist and their team visit the centre as required to review residents. Medication is reviewed to ensure optimum therapeutic value.

Access to allied health professionals to include speech and language therapist, dietetic service and occupational therapy were available.

Specialised supportive equipment including pressure relieving mattress and cushions were used as preventive measures. Supportive aids were evident including walking frames and residents were individually supported to maintain their independence as their capacity allowed.

There was ongoing monitoring of residents nutritional and hydration needs. Each resident's weight was checked monthly. Those at high risk were weighed more frequently. Staff monitored the food and fluid intake of residents identified with a nutritional risk. However, fluid charts were not always totalled to ensure a daily fluid goal was achieved.

The centre's policy was all residents were for resuscitation unless documented otherwise. The clinical judgement of the general practitioner was documented in the medical file. However, there was not a system developed to ensure residents with a do not resuscitate (DNR) status had the DNR status regularly reviewed to assess the

validity of clinical the judgement on an ongoing basis.

Judgment:
Non Compliant - Moderate

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

Theme:
Workforce

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

Findings:
There was an adequate complement of staff with the proper skills and experience to meet the assessed needs of residents during the day taking account of the purpose and size of the designated centre. An additional care staff has been rostered since the last inspection during the day. However, the inspector found that the nurse staffing levels require review to ensure adequate resources are available each evening until the majority of residents have retired to bed.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. Staff confirmed to the inspector they undertook an interview and were requested to submit names of referees and complete Garda Siochana vetting. There was a low turnover of care staff since the last visit by the Authority ensuing continuity and familiarity in care for residents.

There was a training matrix available which conveyed that staff had access to ongoing education. The inspector found that in addition to mandatory training required by the regulations staff had attended training on infection control, medication management, and cardio pulmonary resuscitation techniques. However as identified under Outcome 7, Safeguarding and Safety, all staff were not trained in the management of behaviours that challenge.

Judgment:
Substantially 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:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Summerville Healthcare
Centre ID:	OSV-0000397
Date of inspection:	21/07/2015
Date of response:	01/09/2015

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some polices remain outstanding for review to ensure they are fully centre specific. Namely the adult protection, medication and risk management policies.The policy to guide staff action and intervention in responding to behaviours that challenge requires review.

1. Action Required:

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

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

Please state the actions you have taken or are planning to take:
Adult Protection 31/10/2015

Medicines Management 30/11/2015

Risk Management 31/12/2015

Behaviours that challenge 31/12/2015

Proposed Timescale: 31/12/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The most recent transfer by a resident to hospital was not recorded in the directory.

2. 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:
This was updated on the evening of the inspection 21/7/2015.
Allocate responsibility for ensuring directory is updated to Administration.

Proposed Timescale: 12/09/2015

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:
Practice was not fully reflective of the national policy on promoting a restraint free environment as there were no details why the alternatives trialled were unsuccessful.
There was no rationale detailed to outline how the raised bed-rail supported the resident and ensured an enabling function.
The risk assessments were not revised at frequent intervals in line with other assessments.
There was conflicting information between the risk assessment and care plans and the

daily handover report.

3. 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:
(1) Flo-chart for staff to help support in decision making
(2) Epicare update to ensure staff can utilise the system and all bed rails, as an enabler will have time put up and time taken down.
(3) Yellow colour Stickers in residents notes updated on 3 month review with GP signature and Physio Signature to show multi-professional consensus.
(4) Handover sheets to be checked and updated daily to avoid conflicting information. Actioned.

Proposed Timescale: 30/09/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff were not trained in the management of behaviour that is challenging.

4. 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:
Staff updates: Training Matrix to be updated with staff that attended a Behaviour that is Challenging training course on 5/6/15. Any remaining staff to be trained will be scheduled for course on next available date.

Proposed Timescale: 31/12/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A small number of staff were identified as requiring refresher training in fire safety.

5. Action Required:

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

Please state the actions you have taken or are planning to take:
Staff training and documentary evidence to be updated.

Proposed Timescale: 31/10/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risk assessments were completed to identify the mobility needs of residents in the event of a fire but a review was required to ensure they were maintained up to date.

6. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
(1) Risk assessments updated

Proposed Timescale: 01/09/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no records to evidence all staff had the opportunity to participate in fire drills in addition to annual training.

The fire drill records did not record the time taken for staff to respond to the alarm.

The drills did not record the scenario/type of simulated practice.

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

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

More comprehensive records for fire drills highlighting
(1) Time specifically for staff to respond to the drill
(2) Listing of staff to ensure all staff have participated in the fire drills especially at night
(3) More specific information in relation to scenario and simulated practice
Proposed Timescale: New Template to incorporate the above 30/9/2015

Proposed Timescale: 30/09/2015

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was not a system developed to ensure residents with a do not resuscitate (DNR) status had the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

Fluid charts were not always totalled to ensure a daily fluid goal was achieved.

Care plans for residents with dementia or behaviours that challenge required review to ensure they are more person centred.

Other plans of care to meet the psychosocial needs of residents require review to ensure they are person centred

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

Please state the actions you have taken or are planning to take:
There was not a system developed to ensure residents with a do not resuscitate (DNR) status had the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

Red stickers which highlights in the medical notes details of the date of update of the decision GP Signature and Family and nurse where appropriate This will demonstrate at a glace on the 3 monthly reviews that the clinical judgement has been reviewed. 30/9/2015

Care plan support epicare 1-1 for nursing staff August 2015-08-31

Epicare update for care staff to monitor fluid balance charts - Actioned -August 2015

Proposed Timescale: 30/10/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The nurse staffing levels require review to ensure adequate resources are available each evening until the majority of residents have retired to bed.

9. 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:
Skill mix and nurse staffing will be reviewed in relation to dependency.
Management team to review staffing levels evening and night

Proposed Timescale: 30/10/2015