# Compliance Monitoring Inspection report

Designated Centres under Health Act 2007, as amended

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Nazareth House</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000369</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Church Hill, Sligo Town, Sligo.</td>
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<tr>
<td>Telephone number:</td>
<td>071 918 0900</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:lorrainenaz@eircom.net">lorrainenaz@eircom.net</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Nazareth House Management Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Patrick Gaughan</td>
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<tr>
<td>Lead inspector:</td>
<td>Marie Matthews</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>61</td>
</tr>
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<td>Number of vacancies on the date of inspection:</td>
<td>9</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>01 April 2015 10:00</td>
<td>01 April 2015 18:30</td>
</tr>
<tr>
<td>02 April 2015 10:00</td>
<td>02 April 2015 19:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Major</td>
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**Summary of findings from this inspection**

This monitoring inspection was unannounced and took place over two days. It was the sixth inspection of the centre by the Authority. As part of the inspection, the inspector met with residents and staff members, observed practices and reviewed documentation such as care plans, medical records, policies and procedures, medication records and risk management documentation including fire safety and accident and incident records. Changes had occurred to the senior management team since the last inspection. Three senior staff members had left their posts and a new Person in Charge (PIC) had been appointed.

The inspector followed up on the actions from the previous monitoring inspection carried out by the Authority in April 2014 and found that some actions had not yet been addressed. The provider had failed to address an action in relation to staffing levels and the inspector identified again on this inspection that the levels and deployment of staff were still inadequate. An immediate action was issued requiring the provider to take immediate steps to address this issue. A major non-compliance was identified with the regard to fire safety training for staff. An immediate action was also issued requiring the provider to address this.

Actions relating to care planning had not been adequately addressed and some care
practices observed were not evidence based. There was evidence of poor clinical governance and supervision of staff. Documentation associated with two allegations of abuse were reviewed by the inspector during the inspection and it was found that comprehensive investigations had taken place. However, some staff members were unclear as to who they should report such incidents to and some were overdue training in adult protection.

The Action plan at the end of this report identifies the improvements required to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The two immediate actions issued were subsequently followed up by the inspector on the 13th of April 2015 and both actions had been appropriately addressed. The provider responded within the required time-frame to address both actions.
Outcome 02: Governance and Management

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

Theme:
Governance, Leadership and Management

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

Findings:
On the first day of inspection the inspector was informed that the person in charge had resigned. Discussions were taking place with the provider to deploy the person in charge from another centre owned by the company to this role. This was confirmed during the inspection. The provider agreed to notify this change to the management structure to the Authority following the inspection.

Some actions from the previous inspection had not been satisfactorily completed. The provider was required to review staffing levels; however there was poor evidence that any meaningful review of staffing levels had taken place and the inspector identified that residents needs were not been appropriately met by the current levels or deployment of staff. Two Clinical Nurse Managers level 2 (CNM2) had resigned in April and in June 2014 and had not been replaced at the time of inspection and there was a lack of supervision of clinical care as a result. One staff member had returned to the service after a period of leave and was working as a staff nurse. The inspector was told that she would be appointed to the role of Clinical Nurse Manager 2 and would be responsible for supervising clinical care. This staff member had commenced in this role when the inspector returned on the 13 April 2015.

Practice in relation to auditing the safety and quality of the service had improved and systems were in place to gather information on key clinical performance indicators including falls, weight loss, complaints, wounds, restraint, call bell responses, psychotropic drug use, antibiotic use, care planning, catheter care and infections on a monthly basis. A report on the various audits conducted for the purpose of Regulation 35 was available and a quality improvement plan was included in the report compiled. Although forums were established for residents, the inspector did not see any evidence that information collected as a result of audits or reviews was conveyed to residents.
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<tr>
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<th>Non Compliant - Moderate</th>
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### 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:**
As discussed in outcome 2, the Director of Nursing had left her position and a new Person in Charge (PIC) had been appointed. She was previously person in charge of Ballymote Community Nursing Home and is a registered general nurse with the relevant necessary experience. She stated that she would be working on a full-time basis in the centre. She demonstrated a good clinical knowledge and was aware of her responsibilities under the Regulations. She identified that she would be supported in her role by a newly appointed clinical nurse manager level 2 (CNM2) who would deputised in her absence. The Provider was requested to formally notify this change of management to the Authority and subsequently did so.

**Judgment:**
Compliant

### Outcome 07: Safeguarding and Safety

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

**Theme:**
Safe care and support

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

**Findings:**
Residents told the inspector that they felt safe and were complimentary of the staff caring for them. Interactions observed between staff and residents were found to be
respectful. A policy was available to guide practice however the policy required review to reflect the new governance arrangements.

Two protections issued reviewed by the inspector concerned allegations that a family member had abused residents and two further allegations related to a resident with advanced dementia entering other residents’ bedrooms. A further two allegations related to the care and welfare of residents and the inspector saw that a comprehensive investigation had been completed into each incident by the person in charge and appropriate action taken to safeguard residents. The families of the residents were notified and the designated officer was involved in the investigations. The inspector found however, that although the staff interviewed were aware of what constituted abuse, some staff were less sure of whom to report a suspicion of abuse to. Records reviewed also confirmed that most staff had completed training in the prevention of elder abuse but a small number were overdue this training.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
A risk register was available which was regularly updated as risks occurred. Measures were in place to prevent accidents and promote residents’ mobility. Handrails were provided on both sides of the corridors and assistive devices were provided to promote residents’ independence. Other measures to reduce falls included crash mats and chair sensor alarm.

Records were maintained of all accidents and incidents in line with evidence-based practice. All residents who sustained a fall were subject to neurological observation to ensure that they did not sustain a head injury. Residents who had a fall were reviewed by their general practitioner (GP) and were referred to a physiotherapist for assessment. However, the inspector found that the falls risk assessments was not always reviewed to ensure it reflected the current assessed needs/risk of the resident.

Measures were in place to control the spread of infection. These included the provision of personal protective equipment. The environment was noted to be clean on the days of the inspection. Training records reviewed indicated that all staff had not completed recent training in infection control.
The inspector viewed the fire records which confirmed that fire equipment had been regularly serviced. Electro-magnetic self closing fire protection doors were provided in each bedroom and between each fire zone. Each resident had a personal emergency evacuation plan completed. Staff interviewed were aware of how they would evacuate the building if the need arose however the training records for fire safety indicated that several staff including some who were on the rota for night duty, had not completed fire safety training in the last year.

Although the staff were observed to use appropriate manual handling techniques, training records reviewed by the inspector indicated that a small number had not received mandatory training in safe manual handling techniques in the last three years.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration but it had not been reviewed since 2010.

Medication was supplied by a local pharmacy for residents. Each individual medication was supplied to the centre in blister packs organised in sections marked morning afternoon, evening and night time. From the inspectors’ observation of the morning medication administration round and from discussions with nursing staff, it was clear that medication administration was very time consuming. The medication round commenced at 8.30 am and went on until after 11.30am. The inspector reviewed the prescription sheets and medication records for three residents. The times of administration did not correspond with the times recorded on the medication administration sheet (MARS). For example, some residents were only receiving their morning medication at 11.20am even though the time ticked on their MARS was 8am. The inspector also observed that the nurse left the medication trolley unattended outside the resident’s bedroom while administering medication, which posed a potential risk to other residents.

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

Theme:
Effective care and support

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

Findings:
Care planning and the provision of evidence based care were found to be inadequate on the last inspection of the centre in April 2014 and was the subject of action plans. The inspector found that these were not adequately addressed as reflected in the findings of this inspection.

The inspector reviewed four care plans in detail and aspects of others. Residents had good access to GP services and an out-of-hours GP service was available. Residents had access to dental and optical services.

Access to health professionals including physiotherapy and occupational therapy (OT), speech and language therapy (SALT) and dietics was evident in the care plans. However in the sample of care plans reviewed, the recommendations of the specialist was not always incorporated into the care plans and used to inform care. A comprehensive assessment of the activities of daily living was completed for each resident and clinical risks such as the risk of developing pressure ulcers, or falling were assessed and risk rated. Care plans reviewed were not always updated where there was a change in the resident’s needs. For example, one resident had returned from hospital after sustaining a fracture as a result of a fall; however the resident’s falls assessment and care plan had not been reviewed to reflect this change. There was some evidence of involvement of the resident or their relative in the care plans; however, there was not always any narrative recorded of any discussions held.

There appeared to be some confusion between care plan goals and care plan evaluations and the care plans were not always appropriately linked to give an overall or global view of the resident’s care. For example nutritional care plans did not include the advice of the Speech and Language Therapist (SALT) and dietician and skin/pressure area care plans were not linked to nutritional care plans. Practice in relation to monitoring residents’ nutritional and fluid intake also required review. Although food and fluid balance records were available for those residents identified as ‘at risk’ of weight loss or dehydration; the inspector observed that fluid balances records were not totalled at the end of each day to show the total quantity of fluids consumed action they should take and there was no directive to staff as to what action to take where a resident consumed less than the recommended quantity of fluids. The inspector saw that in some
instance one resident had consumed less than 350mls of fluid, there was no reference to remedial action taken. Similarly there was evidence that residents’ weights and health statistics were monitored monthly however there did not appear to be any guidance /early warning system in place to prompt staff as to what action to take where deterioration in the residents’ health was evident from these results. The PIC said she was hoping to adopt the system used in acute hospitals.

Practice in relation to restraint management was not in accordance with evidence based practice. Of the 61 residents accommodated, 60 used bed rails. The PIC said that most bed rails were requested by the residents for security or as an enabler and this was documented in their notes however, where bed rails were used for safety there was no evidence that less restrictive options were tried first and there was not always evidence of the involvement of a multidisciplinary team in restraint assessments.

Practice in relation to wound care was also found to require improvement. This was also highlighted on the last inspection. In one wound care plan reviewed, there were no wound measurements or photographs of the wound included in the care plan to help staff to assess if the wound was healing.

Staff had not completed any training in care planning and from the documentation reviewed did not appear to be clear on the purpose or methodology of completing care plans to guide care. While the above deficits were observed in documentation of residents care plans, residents and relatives interviewed told the inspector they were very well cared for.

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

**Findings:**
Inadequate staffing levels and skill mix were the subject of an action plan from the last
inspection of the centre in April 2014 and the provider was requested to complete a review of staffing levels to ensure residents’ care needs were appropriately met. There was no evidence provided during this inspection that this action was addressed or that such a review had taken place.

A copy of the staffing roster was reviewed by the inspector was found to accurately reflect the staff on duty on the day. There was a registered nurse on duty in the centre at all times. The centre is arranged in two distinct units each arranged over two floors. There is a considerable distance between the entrances to the two units. The normal allocation of staff on duty during the day was 4 nurses and 10 care assistants between the two units. This reduced to 4 nurses and 6 care assistants in the evening and then to two nurses and four care assistants up until 10.30 pm at night. From 10.30pm until 8am staffing levels reduced to two nurses and two care assistants. (a nurse and a care assistant in each unit covering two floors). Staff interviewed told the inspector that normal practice was for the nurse and care assistant to work together on one floor until the medication round was completed. This resulted in residents being left unsupervised on the other floor. The provider stated that a call bell system linked to a mobile handset was used by staff however the inspector observed during the inspection that some residents who were in bed did not use the call bell system.

The inspector identified further evidence during the inspection that staffing levels were not ensuring residents’ needs were adequately met. The inspector reviewed the falls records for 2014 and the first two months of 2015. There was an average of 9 falls per month during the previous year and 11 per month for 2015. The inspector saw that of the falls that had occurred during the first quarter of this year, almost 30% were unwitnessed and 50% occurred between 12am and 8am. On several occasions during the inspection, the inspector observed residents left unsupervised for long periods of time. The inspector observed care in the morning. Most residents required the assistance of two staff. Once residents were assisted to get up and dressed after breakfast, they were led to the sitting room where they were left unsupervised while staff returned to assist the other residents.

51 of the 61 residents were assessed as having high to maximum dependency levels and many had impaired mobility and required the assistance of two staff to transfer from bed to a wheelchair. The inspector was also informed by staff that due to a staff shortages as a result of illness the previous day, several residents had to remain in bed as there were not sufficient staff to assist them to get up.

As discussed under outcome 11, there was a lack of supervision of clinical care practices which was apparent in the recording of residents care notes and two Clinical Nurse Manager positions had been vacant for some time. (One position has subsequently been filled)

A staff training matrix was maintained and recorded staff attendance at training to support their professional development. However, training records confirmed that not all staff had attended mandatory training in fire safety or manual handling as required. As a result of these findings, an immediate action plan was issued. The provider responded within the required time frame stating that staffing levels at night-time had been increased. This was verified on a follow up inspection on 13 April 2015. The new PIC
stated that staffing levels had been increased by one at night and that this was being reviewed further in the context of an overall review of staffing rotas as a priority.

**Judgment:**
Non Compliant - Major

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Marie Matthews  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
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:
Residents’ needs were not being appropriately met by the current staffing levels, deployment of staff and management structures in place.

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

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

Page 13 of 20
Please state the actions you have taken or are planning to take:
A new P.I.C is in post since April 1st 2015 to coordinate and oversee the whole service ensuring that best practice is achieved to meet the needs of all the residents. A new Clinical Nurse Manager 2 is in post since April 3rd 2015 to ensure effective clinical supervision in achieving and maintaining standards whilst supporting staff to achieve this.
A new HR manager has commenced in post since 11th May 2015 to monitor absenteeism levels and support the PIC in recruitment of staff. A new Cleaning manager has been appointed and is in Post since the beginning of June. This will free up Nurse managers to deal more directly with care issues.
A recruitment campaign has ensured the employment of new nursing and care staff to address the requirement to comply with adequate staffing. Adequate resources have been employed to match the needs of the service. Since April 25th 2015 two new staff nurses have been recruited as well as three new care staff. From June 6th 2015, staffing levels have increased on night duty.

The new PIC has completed a comprehensive staff review since the date of inspection with each staff member on an individual basis to address and reflect the service requirements of the organisation. As a result of that review, rosters have been radically overhauled and rationalised allowing a better deployment of staff. This has been agreed and in place since April 25th 2015.

Proposed Timescale: 17/07/2015

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:
Staff interviewed were aware of what constituted abuse however, some staff were less sure of who to report a suspicion of abuse to and required further training

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

Please state the actions you have taken or are planning to take:
The Protection of Vulnerable Adults Policy (Elder Abuse) is being reviewed and updated regarding the reporting structures in the case of an alleged abuse.
The protection of vulnerable adults from Abuse course will be delivered to all staff.

Proposed Timescale: Start 27th May to end of June 2015
### Proposed Timescale: 30/06/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some staff had not completed training in protection the last 3 years.

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

Please state the actions you have taken or are planning to take:
The Protection of Vulnerable Adults Policy (Elder Abuse) is being reviewed and updated regarding the reporting structures in the case of an alleged abuse. The protection of vulnerable adults from Abuse course will be delivered to all staff.

Proposed Timescale: Start 27th May to end of June 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:**
There was not always evidence of learning from serious incidents where residents sustained a fall. Falls risk assessments reviewed were not updated to ensure they reflected the current assessed needs/risk of the resident.

#### 4. 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:
The new PIC will review the risk management policy and update it to ensure that learning from serious incidents occurs. In addition, a new health and safety committee has been set up to address H&S issues that arise. Audit findings post falls will be addressed and actioned with all parties involved ensuring safe care of the resident.
### Proposed Timescale: 30/09/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All staff had not completed fire training in the last year.

**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:**
Since April 1st the new PIC has ensured that all staff has been trained in Fire Safety for 2015. New staff that have commenced in post since 24th April 2015 will be trained by September 2015. Whilst awaiting this training, new staff will be briefed on fire safety on their induction to the workplace.

### Proposed Timescale: 09/09/2015

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The times of administration did not correspond with the times recorded on medication administration sheet (MARS).

**6. 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:**
Following consultation with the Pharmacist, a new drug administration system has been introduced to the nursing home since May 3rd 2015. Nursing staff have been educated in the use of this system. A constant review of this system by staff and Pharmacy is in place. Nursing staff will have their competency assessed in the administration of medications by the Clinical Nurse Manager and its findings audited and actioned.
**Proposed Timescale:** 31/08/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A nurse left the medication trolley unattended outside the resident’s bedroom while administering medication.

**7. 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:**
Following consultation with the Pharmacist, a new drug administration system has been introduced to the nursing home since May 3rd 2015. Nursing staff have been educated in the use of this system. A constant review of this system by staff and Pharmacy is in place. Nursing staff will have their competency assessed in the administration of medications by the Clinical Nurse Manager and its findings audited and actioned. In addition, the nursing staff has changed their practice in accordance with their professional responsibility and accountability and now take the medication trolley into each resident’s room and the practice of leaving the trolley unattended has now ceased.

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**Proposed Timescale:** 17/07/2015

**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:**
Care plans were not reviewed to reflect a change in the residents needs

**8. Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**
The new PIC and CNM2 are undertaking a complete review of the Care Planning system currently in place to reflect the needs of the resident and to ensure its effectiveness as a whole. Staff require support to effectively address the needs of the resident with regard to nursing documentation. Training workshops will be organised to inform and educate staff regarding nursing documentation and evaluation.
**Proposed Timescale:** 30/09/2015

**Theme:**
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Practice in relation to wound care, restraint, and clinical recording of clinical practice was not always evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

9. **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:
The new PIC and the CNM2 are addressing the findings regarding nursing practice. A training needs analysis has been completed. Links with the Centre of Nursing and Midwifery Education Sligo and the Nursing and Midwifery Practice Development Unit have been made by the PIC to address the findings of the training analysis.

Training in Tissue Viability has been completed, and a Link nurse has been identified. This Link nurse, as well as another nurse, CNM2 and a CNS in tissue viability are currently working as a team to update and implement evidence based care bundles for wound management.

Restraint training will be scheduled.

**Proposed Timescale:** 30/09/2015

### Outcome 18: Suitable Staffing

**Theme:**
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and deployment of staff was not appropriate to ensure the needs of residents were met. The required review of staffing levels and allocation as previously identified was not undertaken.

10. **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:
A comprehensive staff review has taken place since the date of inspection with each staff member on an individual basis with the P.I.C. to reflect the service requirements of the organisation. A new rostering system is in place as a result of that review since April 25th 2015. This review ensures that the appropriate skill mix is available over a 24hr period and the needs of the residents are being met. The new rostering system ensures that the appropriate numbers of staff are available throughout the day and night and that staff are engaging with residents in a meaningful way. The number of night staff on duty has been increased commensurate with bed numbers. In addition, the organisation of work has been addressed to ensure the staff nurse can be released to focus on their nursing duties and developing and defining their role. As outlined previously, we have recruited additional management staff to assist in the areas of HR management and Cleaning.

**Proposed Timescale:** 17/07/2015

**Theme:** Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff have not completed training in manual handling

11. **Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
The Nursing Homes policy on Moving and Handling training states that it is required to be completed every three years for each staff member. Records show that this training is in date for most staff and some staff were due for renewal in June 2015, we have now scheduled manual handling training for the 23rd and 24th of July and will complete all manual handling training for staff be the end of September.

**Proposed Timescale:** 30/09/2015