<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Ratoath Manor Nursing Home</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000152</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Ratoath, Meath.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 825 6101</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:ratoath@silverstream.ie">ratoath@silverstream.ie</a></td>
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<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<td>Registered provider:</td>
<td>Ratoath Nursing Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Joseph Kenny</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<td>Type of inspection</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>59</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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: 06 January 2016 09:45 To: 06 January 2016 18:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk</td>
<td>Non Compliant - Major</td>
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<tr>
<td>Management</td>
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<td>Outcome 10: Notification of Incidents</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Consultation</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection
This was the eighth inspection of the centre by the Authority and was completed to monitor ongoing compliance with the regulations. The inspector reviewed ten outcomes in addition to progress with completion of the action plan from the last inspection of the centre in January 2014. The inspector found that some action plans were not satisfactory completed from the last inspection and are restated in the action plan with this inspection.

On this monitoring inspection, the inspector found major non-compliance in relation to risk management and an immediate action plan on areas of fire safety was issued to the provider. The provider took immediate action to mitigate the risks found and communicated details of his actions to the Authority on the 08 January 2016 as requested.

The inspector also observed areas of good practice and further areas where improvements were required. The person in charge and management team acknowledged the areas for improvement. They stated they had already identified
many of these areas and were commencing work on developing actions to address them this year, with the appointment of their new person in charge.

Residents expressed satisfaction with services and the care provided and staff interactions with resident interactions were to be respectful and supportive.

The inspector found moderate non-compliance in relation to the management of restrictive procedures and care planning. Mandatory staff training requirements were not fully met. The inspection findings also supported a need to review staffing levels and skill mix to ensure residents' holistic needs were met. There was inadequate specialist follow-up referral of residents with unintentional weight loss and inadequate assistance was provided to residents experiencing challenges with eating. While improvements made to date are acknowledged by the Authority, further work is required to meet the social needs of residents, especially residents who remained in bed or in their bedrooms during the day.

The inspector requested additional information to be completed and submitted by the person in charge, to provide assurances that the needs of residents with unintentional weight loss and residents with dementia care needs were met.

The Action plan at the end of this report identifies mandatory improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
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:
An updated statement of purpose was forwarded to the Authority by the provider with revisions made following the change of person in charge. This document accurately describes the service that is provided in the centre. All matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were included in the statement of purpose.

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 lines of authority and accountability were clearly defined in the management structure of the centre on the day of inspection. Changes have taken place in personnel in some key management positions since the last inspection in January 2014, the most
recent being the Person in Charge. Manpreet Kaur is the person in charge of the designated centre since 04 January 2016.

There was a system in place to review, monitor and improve the quality and safety of care. While the quality of life for residents in the centre was evaluated through feedback from meetings and day to day discussion with residents and their families, The management team acknowledged this during discussion with the inspector and stated that this would be completed. However, evidence was demonstrated on inspection of improvements made as a result of action taken on feedback received and audits completed. Some examples included improvements in provision of social activities for residents and consultation regarding care activities. A comprehensive focused review of the quality of life for residents in the centre was not completed to date.

Procedures were in place where serious incidents involving residents was addressed at local level and forwarded to senior management.

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

Findings:
The inspector found that there were measures in place to safeguard residents and to protect them from abuse. On the day of inspection there were no allegations of abuse being investigated. The inspector observed that appropriate measures were put in place following investigation of an incident in 2015 involving two residents to prevent reoccurrence. No further incidents were recorded. Two of the three resident areas were occupied by residents with dementia care needs. The inspector visited one of the areas occupied by residents with dementia and focussed on their care. The inspector observed that residents were appropriately supervised by staff in this area on the day of inspection. Behavioural support plans were developed for residents presenting with behaviour that challenged. The management team were in the process of developing a behavioural support plan for one current resident and had a multidisciplinary team meeting scheduled to finalise the plan for implementation. The staff training records confirmed that staff had attended training on dementia and managing behaviour that challenged. On review of the staff training records on protection of vulnerable adults, it
was evident that twelve staff including five staff nurses had not attended this mandatory training. All staff-resident interactions observed by the inspector were respectful, supportive and empowering on the day of inspection. Residents spoken with by the inspector were complimentary in their feedback on staff caring for them and the care they received in the centre.

There was an additional charge to residents for social care and activity provision. On the last inspection, the provider was requested to make a list of all services provided for this charge available to residents for their information. This action was completed on this inspection.

Bedrails were in use for a number of residents. The inspector observed some residents in bed during the day of inspection had bedrails in use on their beds. Releasing schedules were available. Each resident using bedrails had a risk assessment completed. There was no documentary evidence to support actions taken to reduce bedrail use. This finding was not in line with the recommendations of the National Restraint Standards or the requirements of the regulations. However, this finding was also acknowledged as an improvement to be implemented by the management team during the inspection feedback meeting. The staff training records confirmed that some staff had attended training on use of bedrail restraints.

**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:**
The inspector followed up on the actions from the last inspection and found that the actions required were partially implemented. While there was a process in place where risks in the centre were identified with stated controls to mitigate occurrence implemented, not all risks to residents were identified. The inspector observed that the floor structure in corridors on the first floor was ramped in some areas. While the risk of vulnerable residents falling was identified and addressed in one ramped corridor area, with the placement of horizontal anti-slip surface strips, this control was not documented. The potential risk posed by the other ramped corridor areas was not identified. Although the risk posed by stairs to vulnerable residents on the first floor was identified with appropriate controls implemented in practice, this was not documented in the risk register. This issue was also found on the last inspection in the centre.
A record of all accidents and incidents to residents was maintained and viewed by the inspector. There were also appropriate arrangements in place for the identification and investigation of accidents and incidents. Evidence was demonstrated of actions implemented to prevent reoccurrence. For example, implementation of supervision schedules and placement of alarm mats to monitor movement of some residents following peer to peer incidents was demonstrated.

The inspector reviewed the records for maintenance of fire safety equipment in the centre and they were completed accurately and at appropriate intervals. Each residents' evacuation needs in terms of equipment and assistance required was assessed and documented for reference. However, the inspector observed that there was an absence of emergency signage located in a number of areas in the centre. A corridor was blocked on one side by storage of resident equipment and furniture which could hinder evacuation if required. The inspector also observed that the areas under stairways was used for storage of equipment. These findings were demonstrated on-site by the inspector to the provider who undertook to address them with immediate effect as required by the Chief Inspector.

Fire safety training and evacuation drills was completed by staff and staff spoken with were able to identify the actions to be taken in the event of an emergency. However, five staff members were not recorded as having attended fire safety training and evidence was not available of completion of fire evacuation drills to test night-time conditions including reduced staffing levels in the centre.

The staff training records referenced that three staff members had not attended mandatory training provided in safe moving and handling procedures. All moving and handling procedures observed by the inspector were carried out safely by staff in line with best practice. This finding is addressed in outcome 18.

**Judgment:**
Non Compliant - Major

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**Outcome 10: Notification of Incidents**

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

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

**Findings:**
There was a record of all accidents and incidents that occurred in the centre. The legislative requirement to submit relevant notifications in a timely manner to the Chief Inspector has been adhered to. The inspector reviewed the notifications of serious injury
to residents and quarterly reports which had been submitted to the Authority and were satisfied that they were responded to appropriately and complete.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
The inspector reviewed a sample of care plans. There were appropriate nursing assessments in place for each resident and the care plans were developed as a result of the needs identified. While improvements had been made in the development of care plans since the last inspection, further improvements were found to be required to ensure the care plans informed interventions necessary to meet residents’ assessed needs. For example, recommendations made as an outcome of a consultation by an allied health professional was recorded in the resident’s care plan evaluation and not as care interventions for implementation.

Regular review of care plans and changes to care were recorded. Staff told the inspector that residents and/or their next of kin were involved in care plan reviews, however there was no documentation to support this. The inspector observed that residents and/or next of kin were advised to make an appointment with the person in charge to discuss care plans. However, this arrangement may require review to incorporate care plan reviews with residents and/or their next of kin as part of the care planning procedure at each unit level.

There was evidence of access to medical services and referrals to Allied Health Professionals, however as found on the last inspection, the inspector observed that there were deficits in making medical referrals and follow up referrals to allied health professionals where recommendations implemented did not result in an improvement in a resident's health. For example for a resident with progressive unintentional weight loss. Daily progress notes were recorded as required by nursing staff and detailed care provided.

Judgment:
Non Compliant - Moderate
**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:**
The inspector observed that the complaints procedure was displayed. The person nominated to deal with complaints and the process for appeals was identified. A complaints log was maintained which contained details of complaints, investigations and outcomes. While there was evidence that the outcome of complaint investigations were communicated to complainants, there was no record maintained of satisfaction of complainants with the investigation outcomes to ensure referral to the appeals procedure was completed where necessary.

There was one complaint being investigated on the day of inspection which reflected the complaints procedure in the centre. Residents spoken with stated that they felt they could raise an issue with a member of staff if necessary.

**Judgment:**
Substantially Compliant

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

**Findings:**
The inspector observed the lunchtime experience for residents on the ground floor and found that there was choice of two hot dishes and food was prepared to reflect the dietary needs of each individual. Residents spoken with told the inspector that they enjoyed the food they received and expressed their satisfaction with the choice of menu offered. The food was plated in the dining room from a hot-plate unit by the head chef.

The inspector observed the head chef reminding residents of the choice of menu they
had selected the previous day and giving them an option to change their minds which some residents availed of. Consent was sought from residents by staff for their use of clothes protectors during mealtimes.

Residents were assessed for risk of malnutrition on admission and regularly thereafter. There was evidence of residents' weight being monitored on a monthly basis. However, as discussed in outcome 11, deficits were noted in the actions taken following a change in the weight of an individual including follow-up. The inspector requested a review be undertaken by the Person in Charge, of the care and monitoring of residents with documented unintentional weight loss. Since the last inspection all residents with unintentional weight loss are commenced on three day dietary intake monitoring to inform assessment of need for intervention.

The inspector observed that one resident required assistance with eating and another resident required prompting to eat. The arrangements in place to ensure assistance was provided to residents during mealtime required improvement in terms of staff availability. The inspector observed that the head chef was the only member of staff in the dining room with residents for a significant proportion of the time as other staff were engaged in assisting residents to the dining room and meeting the needs of others not present in the dining room.

Snacks were available to residents throughout the day as needed. Residents had access to fresh drinking water and a variety of fluids were available to residents during mealtimes including milk and flavoured water.

**Judgment:**
Non Compliant - Moderate

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**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:**
Inspection findings supported that residents were consulted and involved in the running of the centre. There was a relatives support forum and a residents' committee forum in place, both of which were convened at regular intervals. Agendas and minutes from both meetings were available. An advocate was available to assist residents who required support for two hours each week and contact details were made available to
inspectors observed staff knocking on the doors of residents bedrooms and closing
doors when carrying out personal care to ensure residents' privacy and dignity was
respected. However, the inspector observed that there was no internal locks fitted to
bathroom and toilet doors on the first floor. All personal information was stored securely
to ensure residents' privacy and confidentiality was respected.
The centre was homely, warm and comfortable on the day of inspection. Resident areas
were equipped with items of domestic furniture, such as kitchen dressers and residents
bedrooms were decorated with their personal photographs, pictures and ornaments.
Since the last inspection all multiple occupancy bedrooms have been refurbished to
single and twin bedrooms.
There was areas for residents to meet their visitors in private outside their bedrooms if
they wished. There was evidence of improvements in the social care provided for
residents as a result of an action plan from the previous inspection. The activity co-
ordinator now works over five days, however is required to provide activities in three
distinct resident areas within the centre. Two of these areas are occupied by residents
with dementia. The inspection findings supported that there is still substantial progress
required in provision of social care to meet the assessed interests and capabilities of
residents, especially in ensuring the social care needs of residents who remained in bed
or in their bedrooms are met. The activity co-ordinator provided activities for residents
in the three resident areas of the centre. The inspector observed that staffing availability
to assist with recreational activities was limited as they were busy with meeting
residents' care needs. This finding is also discussed in outcome 18

**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:**
The inspector observed that staffing levels on the day of inspection was reflective of the actual duty roster for the day. There was a registered nurse on duty in each resident area throughout the day and night as required.

While the duty roster confirmed a standard staffing level was maintained and the inspector was told by staff that additional staff were provided at times when the assessed needs of residents required increased staffing resources. The following inspection findings supported that a review of the standard staffing levels was required to ensure the assessed needs of residents were met;

- The social needs of some residents were not met within the existing staffing arrangements.
- Staff support for residents requiring assistance at mealtimes required improvement.
- The night-time conditions were not tested by a simulated fire drill to ensure safe evacuation of residents.

Staff spoken with were knowledgeable about residents' needs. The inspector reviewed the staff training records which confirmed that staff had attended training in nutrition, wound care, medication management, dementia and behaviour that challenged to support and inform their practice. However, some staff as discussed in outcomes 7 and 8 were not recorded as having completed mandatory fire safety, protection of vulnerable adults or safe moving and handling training.

The inspector reviewed a sample of staff files. One staff file reviewed did not contain all the documentation set out in Schedule 2 of Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). There was only one employment reference on file for this staff member however, a second reference was in process.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<td>Date of inspection:</td>
<td>06/01/2016</td>
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<tr>
<td>Date of response:</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A comprehensive focused review of the quality of life for residents in the centre was not completed to date.

1. 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

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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:
An “Annual Review” of the quality and safety of care being delivered is being prepared and finalised. Included in this report will be a review of our incident accident reporting log for 2015 to include trending of falls, pressure sore incidence, medication errors. The annual report will also include a review of our monthly audits (care plan audit, weight review, and restraint audit & physical environment). Furthermore, a review of our complaints logs to identify trends in complaints will be included. In Silver Stream, we have periodic resident meetings, relative meetings led by our in-house advocate, these meetings provide feedback from residents and their families. The minutes of these meetings will be reviewed and form part of the annual review. Moreover, staff appraisals carried out annually by the Director of Nursing in liaison with the Group HR manager, provide staff feedback and be included as part of the review. These reviews are in the process of being carried out and the resulting plans for 2016, based on these reviews, to improve the quality of care and service to our residents are being drawn up.

Proposed Timescale: 17/02/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no documentary evidence to support actions taken to reduce bedrail use.

2. 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:
A review of our Restraint Documentation (Forms) and our Policy & Procedure has taken will be carried out with the Director of Nursing and Nursing Staff to reinforce the Nursing Homes commitment to a “restraint free environment”. Silver Stream has a comprehensive Policy & Procedure on “Use of Restraint” in the home, and is in accordance with national policy.

Where a restraint is being used (after the completion of a “restraint assessment” and authorised in consultation with the resident/ next of kin, GP and other appropriate members of the multidisciplinary team) a care plan will have been drawn up by a staff nurse. This care plan is communicated to the care assistants, GP, resident & their next of kin. The care assistants implement the care plan, and the Staff Nurse monitors the implementation. The Care Assistants will document/chart when the restraint is in use and not in use using the “Restraint Check” form, whilst the RN monitors completion of
the “Restraint check form”.

The staff nurse reviews the Restraint Management Care Plan on an ongoing basis and at least monthly. These reviews assess if the care plan is effective. If effective the resident will continue to require restraint, this review and restraint assessment is signed and dated by the staff nurse.

If the Care Plan is identified as ineffective and or restraint is deemed not appropriate or required, the staff nurse immediately commences reassessment of the resident.

The Director of Nursing will track restraint usage in the home and assure themselves policy and procedures are being followed through regular audit. Furthermore, discussion of restraint and its usage will be part of the Health & Safety meeting held quarterly with the Director of Nursing, and the staff nurses in attendance in the home.

Benchmarking of restraint usage against other homes and review will be carried out by the Group Clinical Governance Team in Silver Stream Healthcare Group.

**Proposed Timescale:** 27/01/2016  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Twelve members of staff had not attended protection of vulnerable adults training.

**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:**  
Elder Abuse Training has been scheduled and will be completed on 14 & 15th February 2016 for these staff members. This will be kept up to date going forward.

**Proposed Timescale:** 15/02/2016

**Outcome 08: Health and Safety and Risk Management**  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The risk posed to residents from ramped areas on corridor surfaces was not identified and risk assessed in the risk register.

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

**Please state the actions you have taken or are planning to take:**
There are 5 ramped areas in the home. The risk posed to residents from these ramped areas has now been marked on corridor surfaces and this risk has been assessed in the risk register.

**Proposed Timescale:** 19/01/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was an absence of emergency exit signage displayed in a number of resident areas in the designated centre.

**5. Action Required:**
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

**Please state the actions you have taken or are planning to take:**
In the interim temporary signage has been installed in all fire evacuation corridors. Furthermore, a memo relating to evacuation procedures is being included in all staff handovers until further notice. On Monday, January 11th 2016 a Chartered Engineer and Fire Consultant, will be onsite to carry out a full review of the layout, positioning, numbers and types of “Running Green Man” directional Emergency Exit signage currently in place at the Centre. Based on this review we will immediately action any recommended upgrades to ensure full compliance with regulation 28(3).

Update 13th January 2016 :
Following a review of the directional escape route signage at the centre with a Fire Consultant, on 11th January 2016 proposals have been drawn up for additional directional signage.
This is comprised of directional emergency exit light fittings, supplemented by additional non-illuminated exit signage.
Temporary non-illuminated signage has already been erected at relevant locations. These will be replaced by manufactured ones on receipt of order placed.
Our Electrical Maintenance Contractor has been instructed to proceed with the installation of the required Exit light signs as a matter of urgency. It is estimated that the installation will be completed in 4/6 weeks (22nd February 2016).

In the interim temporary signage has been installed in all fire evacuation corridors. Furthermore, a memo relating to evacuation procedures is being included in all staff handovers until further notice. On Monday, January 11th 2016 a Chartered Engineer and Fire Consultant, will be onsite to carry out a full review of the layout, positioning,
numbers and types of “Running Green Man” directional Emergency Exit signage currently in place at the Centre. Based on this review we will immediately action any recommended upgrades to ensure full compliance with regulation 28(3).

**Proposed Timescale:** 25/02/2016  
**Theme:** Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Emergency evacuation access on a corridor on the ground floor was blocked on one side by resident equipment and furniture.

The area under emergency escape stairways was used for and contained storage.

6. **Action Required:**  
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:  
The corridor on the ground floor is no longer blocked on one side by residents equipment and furniture. The area under the emergency escape stairways which contains storage has been cleared. All escape routes are reviewed and inspected daily as part of our fire safety checking procedures. The above mentioned areas have been specifically included in the daily checks. This is check is carried out by our Maintenance Man and at weekends by the Senior Nurse on Duty. Clear signs are in place to keep area clear and staff information sessions completed re same.

**Proposed Timescale:** 08/01/2016  
**Theme:** Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Five staff members had not completed fire safety training

7. **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:  
These staff members will complete fire safety training on 28th January 2016. This will
be kept up to date going forward.

Proposed Timescale: 28/01/2016

**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 did not comprehensively inform interventions necessary to meet some residents' assessed needs.

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

Please state the actions you have taken or are planning to take:
The “Identification Record of Daily Needs” form has been reviewed and updated to facilitate nurses and to guide nurses completing the form to comprehensively document necessary interventions required to meet the needs of residents based on “assessment of needs carried” as part of required periodic assessment or an assessment carried out as a result of a change in condition or an accident or incident.

A Sample of Care Plans are audited monthly by the Director of Nursing to assure compliance, issues arising and actions required to achieve compliance are presented to and discussed with staff nurses.

Furthermore, each resident’s care plan is audited at least 3 monthly by the Director of Nursing.

This process is being overseen by the Clinical Governance Team in Silver Stream Healthcare Group.

Proposed Timescale: 28/01/2016

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff told the inspector that residents and/or their next of kin were involved in care plan reviews, however there was no documentation to support this.

**9. 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:
Per Silver stream Policy “to facilitate excellence in clinical care and to meet the needs and preferences of residents and to support them to live well each day, each resident is assessed on admission and regularly thereafter and a “person centered” care plan is developed. This is carried out in consultation with the resident and / or their next of kin.”

The care plan is reviewed regularly and whenever a resident’s condition changes or an incident occurs, resulting changes to the care plan are notified to next of kin. Going forward, when nurses discuss care plan changes with residents they will document this in the care plan, and will be monitored by the Director of Nursing as indicated by reported resident changes in handover documentation, incident accident reports, doctor visit forms and changes in overall health of a resident ie weight loss. Audit of care plan documentation by the Director of Nursing will assure compliance.

The overall process is being overseen by the Clinical Governance Team in Silver Stream Healthcare Group.

Proposed Timescale: 28/02/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were deficits in making medical referrals and follow up referrals to allied health professionals where recommendations implemented did not result in an improvement in a resident’s health.

10. Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
A “Documentation and Procedures Review Group” has been established by the Group Clinical Governance Team to review existing procedures related to falls, restraint usage, & weight management and to ensure or develop procedures that are clear and guide staff. This will include clear instructions as to when referrals to allied health professionals are to be made and when to follow up with allied health professionals where recommendations implemented do not result in an improvement in a resident’s health.
Upon completion of the review and revisions made to procedures, training will be provided to staff nurses and carers.

Auditing of resident care plans on a monthly basis by the Director of Nursing will ascertain compliance and assure the Director of Nursing that nursing staff are making referrals and documenting referrals correctly and as per procedure.

This whole process will also be monitored and reviewed by the Clinical Governance team in Silver stream healthcare Group.

**Proposed Timescale:** 14/02/2016

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### Outcome 13: Complaints procedures

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no record maintained of satisfaction of complainants with complaint investigation outcomes to ensure referral to the appeals procedure was completed where necessary.

**11. 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:**
All complaints going forward will be responded to formally with a written letter. This letter will include investigation outcomes and a section to ascertain if the complainant is satisfied with the outcome of the complaints process.

**Proposed Timescale:** 28/01/2016

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### Outcome 15: Food and Nutrition

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was inadequate numbers of staff in the dining room at mealtime to assist residents.

**12. Action Required:**
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff
are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
The Director of Nursing has carried out a review of their Staffing day allocation sheet and has allocated dining room duties to another staff member from the support team to assist existing dining staff.

This will be monitored regularly by the Director of Nursing to assure themselves that there are adequate numbers of staff available to assist residents at meal times.

Proposed Timescale: 01/02/2016
Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Deficits were noted in actions taken following change in the weight of an individual including referral for follow-up by dietetic services.

13. Action Required:
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

Please state the actions you have taken or are planning to take:
All residents are weighed on admission and weighted monthly following admission. Care staff weigh residents, whilst the staff nurses monitor resident weight. Where significant changes in weight are identified (i.e., a 5% loss in two months or 10% loss in 6 months), the staff nurse must inform the GP in the first instance, and then refer the resident to the dietician or speech and language therapist.

The policy is being updated to clearly highlight the procedure to follow when a resident has significant weight loss, so that it is clear to staff nurses.

Furthermore, on a monthly basis the Director of Nursing carries out a weight audit to assure themselves that referrals are being made and documented correctly as per policy.

The overall process is being overseen by the Clinical Governance team in Silver Stream Healthcare Group.

Proposed Timescale: 14/02/2016

Outcome 16: Residents' Rights, Dignity and Consultation
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no internal locks fitted to bathroom and toilet doors on the first floor.

14. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
A review of all internal locks fitted to bathroom and toilet doors in the home has been carried out by the maintenance manager in the home. Those identified as requiring fixing are now in the process of being fixed.

Proposed Timescale: 04/02/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Provision of social care to meet the assessed interests and capabilities of residents required improvement, especially in ensuring the social care needs of residents who remained in bed or in their bedrooms is met.

15. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
Since the previous Registration Inspection in January 2014 the activity co-ordinators hours had been increased from 17 hours per week to 40 hours per week.

It has been agreed to increase activity hours by a further 21 hours to meet the “sun downing needs” of dementia residents between 1700hrs & 2000hrs.

Proposed Timescale: 01/02/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspection findings supported a review of the number and skill mix of staff is required to ensure they are appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

**Please state the actions you have taken or are planning to take:**
The staffing plan for Ratoath Nursing home is developed annually as part of the Annual Business Plan / Annual Review for Ratoath Nursing Home (& reviewed periodically throughout the year). The RQIA 2009 document “Staffing Guidance for Nursing Homes” is used to undertake the review. The review is carried out by the Group Clinical Operations & Governance Manager, the Person in Charge (PIC) and the Assistant Director of Nursing and the Group Finance Manager.

As per the RQIA guideline document the following are considered during the review
1) The ratio of staff to residents
2) The dependency levels of residents
3) The role of the Group Clinical Governance Team, and the PIC
4) The competency and experience of staff
5) Staff training
6) Workload (Care Quality Indicators-Dependency level changes, Falls rate, Pressure Sore incidence, New Admission rates, results of audits)
7) Categories of Care

This review has been carried out and The Director of Nursing & Clinical Governance Manager and are satisfied that staffing levels and skill mix is appropriate to the needs of the residents, as assessed in accordance with regulation 5 and the size and layout of the designated centre.

It should be noted that Silver Stream Group has invested recently in a full time Bed manager, this will facilitate the Director of Nursing being more available in the home and thus facilitating greater support for staff and improved service for residents.

**Proposed Timescale: 20/01/2016**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff had not completed mandatory fire safety, protection of vulnerable adults or safe moving and handling training.

17. **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:**
Fire Safety Training has been scheduled for 28th January 2016, to bring the mandatory Fire Safety training up to date. Elder Abuse training & Manual handling training will be brought up to date by 14/02/2016

**Proposed Timescale:** 14/02/2016