Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Killarney Nursing Home
Centre ID:	OSV-0000685
Centre address:	Rock Road, Killarney, Kerry.
Telephone number:	064 663 2678
Email address:	managerkillarney@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Limited
Provider Nominee:	Pat Shanahan
Lead inspector:	John Greaney
Support inspector(s):	Michelle O'Connor
Type of inspection	Unannounced
Number of residents on the date of inspection:	54
Number of vacancies on the date of inspection:	2

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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
15 March 2016 09:30	15 March 2016 18:15
16 March 2016 08:45	16 March 2016 15:15

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

Killarney nursing home is two storey premises comprising 56 beds, of which 52 are single bedrooms and two are twin-bedded. The centre is located close to the centre of Killarney on grounds that provide adequate parking for visitors and staff. The location, layout and design of the centre was suitable for its stated purpose and met the needs of the residents in a comfortable way.

During this inspection, which was a monitoring inspection, inspectors met with a number of residents, relatives and staff members. Inspectors observed practices and reviewed records such as nursing care plans, medical records, accident and incident logs, policies and procedures and a sample of personnel files.

Overall, residents' healthcare and nursing needs were met to a good standard. Residents had access to medical and allied health services. Appropriate policies and procedures were in place to protect residents from any form of abuse and residents

had access to advocacy services.

Some improvements, however, were required in relation to safeguarding practices. For example, there was an inadequate response by management when an allegation of abuse had been reported in 2014. Records viewed by inspectors indicated that what appeared to be an abusive interaction of a psychological nature, was not recognised for what it was, and appropriate action was not taken, including the implementation of safeguarding arrangements or conducting an investigation. Additional improvements were required in relation to the identification of performance related issues in staff and the implementation of an appropriate performance development plan, where relevant.

Improvements were also required in the management of restraint, particularly in the risk assessment of residents for the use of restraint and the use of restraint when the risk assessment identifies that it should not be used. Other required improvements included:

- medication management
- submission of notifications
- complaint record
- personnel records.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Findings:
On the days of inspection there were adequate resources available to support the effective delivery of care. There was a clearly defined management structure. The person in charge was supported in her role by a clinical nurse manager. As the person in charge was currently absent from the centre for in excess of one year, the clinical nurse manager had assumed the role of person in charge on an interim basis. She was supported by an acting clinical nurse manager, who was appointed to the role in the absence of the person in charge. The person in charge reported to a regional manager, who in turn reported to the provider nominee.

There was a comprehensive programme of audits that included audits of hygiene/infection prevention and control, human resources, clinical documentation and medication management. There was an annual review of the quality and safety of care completed in July 2015 that included feedback from residents.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:
As already stated under Outcome 2, the person in charge was on long term absence from the centre and a clinical nurse manager had assumed the role of person in charge in the interim. This clinical nurse manager was supported by a recently appointed acting clinical nurse manager.

The clinical nurse manager worked full time, had adequate experience in nursing of the older person and was engaged in the day to day governance and operational management of the centre. Residents spoken with by inspectors were knowledgeable of the clinical nurse manager.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
Evidence of current registration was available for nursing staff. A review of personnel records indicated that most of the requirements of Schedule 2 were met, however, a full employment history was not available for all staff and not all recently recruited staff had been vetted by An Garda Síochána, however, records of vetting from their jurisdiction of origin was available..

Judgment:
Substantially Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the

management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge was absent from the centre for a period in excess of 28 days and the Authority was notified of the absence and of the arrangements made for absence as required by the regulations.

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:
There were policies and procedures in place for the prevention, detection and response abuse. Training records indicated that all staff had received up-to-date training on safeguarding practices. Staff spoken with by inspectors were knowledgeable of what to do in the event of suspicions or allegations of abuse. Residents spoken with by inspectors stated that they felt safe in the centre. The clinical nurse manager stated that she monitored systems in place through observing practice and speaking with residents and staff. There were adequate records available in relation to the management of residents' finances.

Some improvements, however, were required in relation to safeguarding practices. For example, there was an inadequate response by management when an allegation of abuse had been reported to management in 2014. Records viewed by inspectors indicated that what appeared to be an abusive interaction of a psychological nature, was not recognised for what it was, and appropriate action was not taken, including the implementation of safeguarding arrangements or conducting an investigation.

There was a policy in place in relation to the management of responsive behaviour. Where residents presented with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) there were adequate care plans in place for staff to support residents with the behaviour.

There was a policy in place to guide the use of restraint. Improvements, however, were required in relation to the management of restraint. For example, while there was a tool available for staff to risk assess the use of restraint, the scoring system used by staff did not correlate with the scoring system intended for use with the tool. Additionally the use of restraint did not always comply with relevant guidance. For example, bedrails were in place for a resident that was at risk of climbing over bedrails and records indicated that this had happened in practice on a number of occasions. This is not compliant with guidance on the use of restraint. The risk assessment for another resident indicated that they were not at risk of harm from the use of bedrails when records indicated that the resident had become trapped in the bedrails on more than one occasion. It was, however, demonstrated to inspectors that measures had been put in place to minimise the risk of further injury to the resident.

Judgment:
Non Compliant - Major

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

Theme:
Safe care and support

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

Findings:
There was a risk management policy that complied with regulations. There was an up-to-date safety statement. There was a risk register that addressed clinical and non-clinical risks. There was an emergency plan that addressed emergencies such as loss of power, loss of laundry facilities, loss of heat and loss of kitchen facilities. The plan also addressed the safe placement of residents in the event of a prolonged evacuation.

Inspectors reviewed the accident and incident log and found that adequate action was taken in response to individual accidents and incidents. Audits of accidents and incidents were carried out by management at clinical governance meetings and there was a process of feedback to staff to support learning and minimise the risk of reoccurrence. There was also a local health and safety committee that met every three to four months to discuss day-to-day issues in relation to the centre.

There were adequate procedures in place in relation to the management of infection prevention and control. There were an adequate number of clinical hand wash basins

located at suitable intervals throughout the centre and there were an adequate number of hand hygiene gel dispensers at suitable locations.

During the most recent inspection in July 2014, the fire alarm system was overdue quarterly preventative maintenance. Inspectors were satisfied during the current inspection that the fire alarm system and emergency lighting were serviced on a quarterly basis. Suitable fire equipment was serviced annually and available throughout the centre. Procedures for the safe evacuation of residents and staff were prominently displayed. Staff interviewed by inspectors participated in regular drills and fire training, and knew how to respond in the event fire. However, inspectors noted that some in-house daily and weekly checks were not taking place, including checking the fire panel, door fastenings or testing a manual call point or automatic fire detector on the fire alarm system. Fire doors, particularly in a number of bedrooms, were wedged open and this had not been recorded or responded to during daily in-house checks.

Judgment:
Substantially Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Following the previous inspection inspectors recommended that residents should be facilitated to have a choice of pharmacist, where possible, and that meetings between pharmacists and residents should be scheduled on an ongoing basis. During the current inspection, inspectors found evidence that choice of pharmacist was facilitated and that pharmacists were available to residents on a monthly basis for consultation.

Written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents were available. Medications were securely stored and reviewed regularly by a GP. Inspectors viewed evidence of both in-house and external pharmacy audits of medication management being conducted. The centre maintained a register of controlled drugs and MDA drugs were checked by two nurses at each shift handover. Residents were also enabled to self administer their own medications following appropriate risk assessment.

Some improvements, however, were required. Based on a sample of prescriptions viewed by inspectors, nurse transcribing practices were not always in line with An Bord Altranais agus Cnaimhseachais guidelines. For example, one prescription that had been transcribed by a nurse did not contain a nurses signature and one medication on this

prescription was not signed for by the GP. Additionally the medication administration record was not always signed by nurses and it was unclear if medications had been erroneously omitted, refused by the resident or had not been administered based on clinical judgement.

Medications requiring refrigeration were stored appropriately and the fridge temperature was recorded. There were adequate procedures in place for the return of unused/out-of-date medicines to the pharmacy.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
A record of all incidents occurring in the centre was maintained. Based on a review of records of incidents and other records, inspectors were not satisfied that notifications were submitted as required by the regulations. For example:
• incident records indicated that a resident a fallen resulting in bruising and was reviewed by out-of-hours GP services but this was not notified to the Authority
• not all suspicions/allegations of abuse and allegations of staff misconduct were notified to the Authority
• the use of chemical restraint was not included in quarterly notifications to the Authority as required.

Judgment:
Non Compliant - Major

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

Theme:
Effective care and support

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

Findings:
Based on inspection findings, inspectors were satisfied that care plans reflected a more person centred approach to care than had been evident previously. Care plans reviewed indicated residents medical needs were met through timely access to medical treatment and that residents had access to allied health care services. Clinical care was delivered in accordance with evidence based best practice.

Care plans were reviewed on an ongoing basis or at a minimum every four months. While most issues were updated following a change in a residents condition or following review, the care plan for one resident contained conflicting information in relation to current recommended diet. Residents' and relatives participated in the care planning process and consent was obtained where necessary. Where residents declined to participate in recommended activities, their decision was respected.

The electronic care plan system had been upgraded in August 2015. As a result of the upgrade, access to information recorded on the older version of the system, including relevant allied health professional notes and assessments, was not readily accessible to a problem in migrating data. A number of residents were seated in large recliner chairs and while inspectors were informed that residents had been assessed for these chairs by an occupational therapist, these records were not available to inspectors on the days of inspection.

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:
There were policies and procedures in place in relation to the management of complaints that included an appeals process. The complaints process was outlined in the residents' guide and was on prominent display in the centre.

Inspectors reviewed the complaints log and there was evidence of action in response to complaints. Improvements, however, were required in the complaints log as it was not

clear from the records if the complainant was satisfied with the outcome of the complaints process. There was no evidence to suggest that complainants were adversely affected for having made a complaint.

Judgment:
Substantially Compliant

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

Theme:
Workforce

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

Findings:
Based on a review of the roster and observations of the inspector over the course of the inspection there were adequate numbers of staff and skill mix to meet the needs of residents.

There was an ongoing programme of training to support staff provide contemporary evidence-based care. Based on records seen by the inspector all staff had received up-to-date training on fire safety and the prevention and detection of abuse. A number of staff did not have up-to-date training in manual and patient handling. Other training completed by members of staff included infection prevention and control, food safety/hygiene, nutrition, care skills, and medication management.

There was evidence of a programme of induction for new staff and a staff appraisal system for existing staff. However, the staff appraisal system had lapsed and records indicated that when appraisal was done it was not always reflective of actual staff performance. Additionally there was not always a process of performance development implemented where staff records indicated that it was warranted. Evidence of current registration was available nursing staff. A review of personnel records indicated that most of the requirements of Schedule 2 were met, however, a full employment history was not available for all staff and not all recently recruited staff had been vetted by An Garda Síochána, however, records of vetting from their jurisdiction of origin was available. this action is addressed under Outcome 5.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Killarney Nursing Home
Centre ID:	OSV-0000685
Date of inspection:	15/03/2016
Date of response:	19/04/2016

Requirements

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

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

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of current registration was available for nursing staff. A review of personnel records indicated that most of the requirements of Schedule 2 were met, however, a full employment history was not available for all staff and not all recently recruited staff had been vetted by An Garda Síochána, however, records of vetting from their jurisdiction of origin was available.

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

1. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
All staff files have now been reviewed to include full employment history. Garda vetting forms have been processed in respect of all staff.

Proposed Timescale: 01/05/2016

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:
Improvements were required in relation to the management of restraint. For example:
•while there was a tool available for staff to risk assess the use of restraint, the scoring system used by staff did not correlate with the scoring system intended for use with the tool
•bedrails were in place for a resident that was at risk of climbing over bedrails and records indicated that this had happened in practice on a number of occasions
•the risk assessment for a resident indicated that they were not at risk of harm from the use of bedrails when records indicated that the resident had become trapped in the bedrails on more than one occasion.

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:
1.The restraint assessment tool now includes the correct scoring system in order to identify the appropriate use of restraint in the home in accordance with national policy.
2.The bed rail for the identified resident has been removed following assessment and there is now an appropriate plan of care in place to provide supervision and ensure the resident's safety and wellbeing.
3.The removal of the bedrail will ensure that the risk of the resident becoming trapped has been removed. The mattress that had been in use at the time of inspection has been replaced by a static pressure relieving mattress that is a perfect fit for the bed.

Proposed Timescale: 16/03/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some improvements were required in relation to safeguarding practices. For example, there was an inadequate response by management when an allegation of abuse had been reported to management in 2014. Records viewed by inspectors indicated that what appeared to be an abusive interaction of a psychological nature, was not recognised for what it was, and appropriate action was not taken, including the implementation of safeguarding arrangements.

3. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
The PIC will ensure that appropriate measures are in place to protect all residents from abuse in Killarney Nursing Home, including raising staff awareness of the following policies:
• Protection of the Resident from Abuse Policy
• Responding to Allegations of Abuse Policy
• National Policy Safeguarding Vulnerable Persons at risk of Abuse (2014)
• Whistle blowing policy

All staff are required to read the policies again and sign to confirm their understanding of their contents.

Induction for new staff and annual updates for current staff will continue to be undertaken to address educational and training needs for staff on protection of persons at risk of abuse. This will include:
•Prevention of abuse
•Protection from abuse
•Indicators of abuse
•Responding to suspected alleged or actual abuse
•Procedures for protecting residents with particular vulnerabilities

All allegations of abuse will be fully and promptly investigated by the PIC in accordance with current policy and procedures.
A person centred approached to working with vulnerable residents is actively encouraged within the nursing home.
Residents are provided with support and encouragement to ensure that any concern experienced or witnessed is appropriately addressed.
There is an independent advocate available if required.

Proposed Timescale: 30/04/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all allegations of abuse were adequately investigated.

4. Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

Please state the actions you have taken or are planning to take:
All incidents or allegations of abuse will be notified and appropriately investigated in line with Regulation 08(3)
Relating to the incident identified an NF06 has been submitted and an investigation is currently underway.

Proposed Timescale: 29/04/2016

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:
Inspectors noted that some in-house daily and weekly checks were not taking place, including checking the fire panel, door fastenings or testing a manual call point or automatic fire detector on the fire alarm system.

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

Please state the actions you have taken or are planning to take:
All in-house daily and weekly checks are now taking place as required. The daily and weekly fire precaution checking system has been updated to include all areas as required under Regulation 28(1)(c).

Proposed Timescale: 20/03/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire doors, particularly in a number of bedrooms, were wedged open and this had not been recorded or responded to during daily in-house checks.

6. Action Required:

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

Please state the actions you have taken or are planning to take:
All door wedges have been removed.
A plan is in place to install appropriate fire alarm activated door release systems for identified rooms and communal areas.

Proposed Timescale: 30/06/2016

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:
Some improvements were required in relation to medication management. For example:
•based on a sample of prescriptions viewed by inspectors, one prescription that had been transcribed by a nurse did not contain a nurses signature
•one medication on this prescription was not signed for by the GP
•the medication administration record was not always signed by nurses and it was unclear if medications had been erroneously omitted, refused by the resident or had not been administered based on clinical judgement.

7. 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:
•Transcribing of prescriptions by nurses is limited to designated nurses and is only undertaken when the GP is not immediately available.
•Any prescriptions that have had to be transcribed by nursing staff have been signed by the GP within 72 hours, according to the centre's policy and in line with NMBI guidelines.
•The identified kardex has been rewritten to contain the signature of the transcribing nurse and the witnessing nurse in line with NMBI Guidelines.
•A new prescription chart has been signed by GP for the identified resident
•Further medication management training has been provided to ensure that appropriate medication management practice and documentation are adhered to in line with NMBI Guidelines and the policy of the centre.

Proposed Timescale: 20/03/2016

Outcome 10: Notification of Incidents
Theme: Safe care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** A record of all incidents occurring in the centre was maintained. Based on a review of records of incidents and other records, inspectors were not satisfied that notifications were submitted as required by the regulations. For example: •incident records indicated that a resident a fallen resulting in bruising and was reviewed by out-of-hours GP services but this was not notified to the Authority •not all suspicions/allegations of abuse and allegations of staff misconduct were notified to the Authority. **8. Action Required:** Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence. **Please state the actions you have taken or are planning to take:** The PIC and the CNM will review all incidents recorded on a regular basis to ensure that all relevant notifications are submitted to the Authority on a timely basis as required by the regulations. The outstanding notifications have now been updated to reflect been submitted to the Chief Inspector
Proposed Timescale: 21/03/2016
Theme: Safe care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** The use of chemical restraint was not included in quarterly notifications to the Authority as required. **9. Action Required:** Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4. **Please state the actions you have taken or are planning to take:** The use of chemical restraint will now be included in the NF 39 Quarterly report.
Proposed Timescale: 30/04/2016

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:
While most issues were updated following a change in a residents condition or following review, the care plan for one resident contained conflicting information in relation to current recommended diet.

10. 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 resident's care plan has been reviewed and updated to reflect accurate information in relation to current recommended diet.
All care plans will be reviewed at intervals not exceeding 4 months, where possible after consultation with the resident and the family if appropriate,

Proposed Timescale: 18/03/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of residents were seated in large recliner chairs and while inspectors were informed that residents had been assessed for these chairs by an occupational therapist, these records were not available to inspectors on the days of inspection.

11. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
A full occupational therapy review of residents using recliner chairs has been arranged and is scheduled to take place on 21/04/16 and 29/04/16.
The Occupational Therapist will document her recommendations and discuss them with the PIC.
The recommendations of the Occupational Therapist will be included in the residents' care plans and reviewed on a regular basis according to the residents' individual care needs or at intervals not exceeding 4 months.

Proposed Timescale: 29/04/2016

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:
Improvements were required in the complaints log as it was not clear from the records if the complainant was satisfied with the outcome of the complaints process.

12. 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:
It has been established that the complainant was satisfied with the outcome. The concerns/complaints log has been updated to reflect this.
All future complaints will be logged electronically and will be addressed by the PIC, including the satisfaction of the complainant with the response and the learning outcomes and/or improvements in care and service as a consequence of complaints.

Proposed Timescale: 28/03/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff did not have up-to-date training in manual and patient handling.

13. 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:
Manual and patient handling training has been provided for all outstanding staff members and updates will be scheduled on a timely basis in future for all staff.

Proposed Timescale: 05/04/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff appraisal system had lapsed and records indicated that when appraisal was done it was not always reflective of actual staff performance. Additionally there was not always a process of performance development implemented where staff records indicated that it was warranted.

14. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Performance appraisals have been scheduled for all staff who have not received an appraisal in the past 12 months. Self-appraisal forms have been issued to all staff and a schedule has been put in place to ensure that all staff receive an individual performance review on an annual basis, or more frequently if any issues have been identified with staff performance

Proposed Timescale: 30/06/2016