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:	Beneavin Lodge Nursing Home
Centre ID:	OSV-0000117
Centre address:	Beneavin Road, Glasnevin, Dublin 11.
Telephone number:	01 864 8577
Email address:	info@firstcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Beneavin Lodge Limited
Provider Nominee:	John O'Donnell
Lead inspector:	Sheila McKevitt
Support inspector(s):	Deirdre Byrne
Type of inspection	Unannounced
Number of residents on the date of inspection:	63
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
16 May 2016 09:00	16 May 2016 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This monitoring inspection was the first in the centre since July 2014. The 68 bedded centre is spread over two floors.

The management structure within the updated statement of purpose submitted to HIQA was reflected in the centre. Inspectors saw the level of services and facilities outlined in the statement of purpose were available to residents. An annual review of the quality and safety of care delivered to residents was available for review, however, residents input was not reflected within.

Residents and relatives spoken through out the inspection expressed satisfaction with the level of service they were receiving and services provided to them. Staffing levels and skill mix on the day of this unannounced inspection were good. Staff appeared to meeting residents' needs in a holistic and person centred way.

Inspectors found that the nursing and medical care needs of residents were met.

Practices such as the use of restraint and some care practices required review. Medication administration practices reflected best practice some prescription records required revision.

The action plans at the end of this report reflect the outcomes not met on this inspection.

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):
No actions were required from the previous inspection.

Findings:
There was a clearly defined management team with management systems in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. ·

There were a number of new appointments to the management team since the last inspection. HIQA had been notified of the person in charges return from leave, she was present on site and was supported by the Compliance and Quality Manager (CQM), Operations Manager (OM), Clinical Bed Manager (CBM) and one of two Clinical Nurse Managers. Inspectors observed the team having clear roles and responsibilities in supporting the provider nominee and person in charge.

Inspectors reviewed monthly operational reports accumulated by the person in charge and submitted to the operations manager on a monthly basis. The content of this report was than discussed at the monthly management meeting, minutes of which were available for review.

The person in charge had a system in place of regularly auditing different aspects of clinical practice including medication management, care plans and accidents/incidents. These audits were comprehensive reflecting all aspects of the practice being audited, identifying areas of good practices and those requiring improvement. Inspectors observed that where the need for improvement was identified, an action plan was not in place to reflect how, when and by whom these improvements would be actioned.

A copy of an annual review of the quality and safety of care was available to inspectors. The annual review looked at the quality of care delivered in 2015. While this was a comprehensive document in some respects inspectors found that residents and families had not been involved in a consultative manner to inform such a review, and a copy had

not been made available to the person in charge, staff or residents.

There were enough resources to ensure the effective delivery of care, as described in the statement of purpose. ·

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge (PIC) was on duty during the inspection. She commenced in her role on 03 May 2016 and had yet to be deemed fit to hold the post of PIC by HIQA. She was asked to submit a detailed report of her nursing experience to assure HIQA that this included 3/6 years of working with older people. She was contracted to work fulltime, is a registered disabilities nurse and has completed a module in management as part of her Masters in Palliative Care. Residents' spoken with were aware of the change in person in charge.

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):
No actions were required from the previous inspection.

Findings:

The centre was safe and secure, residents spoken with confirmed this.

Records reviewed showed all new staff had completed training in the protection, detection and prevention of elder abuse during their induction programme. Those staff spoken with had a clear understanding of the protection, detection and prevention of elder abuse policy. A refresher training date had been scheduled for those staff due for refresher training.

Bed rails were used as a form of restraint for a number of residents'. The centres restraint policy referenced the National Policy 2011 "Towards a Restraint Free Environment". Although there were some forms of alternative equipment available such as low low beds, alarm mats and crash mattresses available for use within the centre, those trialled, tested and failed were not reflected on the restraint assessment forms prior to a decision being made to use bed rails as a form of restraint. Hence, practice did not reflect the National Policy 2011 "Towards a Restraint Free Environment".

Records of residents' displaying responsive behaviours at the time of this inspection were reviewed. Inspectors saw that psychotropic medications were used as a last resort to manage these behaviours . These medications were reviewed on a regular basis by the residents' General Practitioner. Record tools were being used to record the frequency, time and behaviours displayed by residents', this enabled trends and possible triggers to be identified. However, these triggers and/or de-escalation techniques were not always reflected in the residents' care plan.

There was a safe system in place to store and manage residents' petty cash. Petty cash held on behalf of residents was individualised, records were detailed and reflected monies held. Access to the safe was restricted to management and administration staff. Inspectors observed that the auditing of cash stored was completed.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The health and safety of residents, visitors and staff was promoted and protected.

The centre had a risk management policy, an emergency plan and an up-to-date health and safety statement in place. The risk register was comprehensive. It identified risks

and specific measures put in place to reduce the level of risk. It was updated on a regular basis, having last been updated in April 2016. Inspectors observed that infection control practices were good with hand washing and drying facilities and hand sanitizers available throughout the centre.

Inspectors saw that there was adequate means of escape and fire exits were unobstructed. Floor plans identifying the nearest fire exit were on display throughout the centre.

Records reviewed on inspection showed that the fire alarm was serviced on a quarterly basis and fire safety equipment and emergency lighting was serviced. All new staff had completed fire safety training on induction and those staff due refresher fire training were booked to attend prior to end of May 2016. Those spoken with were clear on what to do in the event of the fire alarm sounding. Records reviewed showed that a mock fire drill was practiced on average once per month. However, inspectors noted that no night time fire drill had been practiced within the past year.

Manual handling practices observed were in line with best practice. Staff who were due refresher training were scheduled to have this training the week following this inspection.

Judgment:
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:
Inspectors reviewed the medication management policy and noted that it included the procedure for prescribing, administering, recording, safekeeping and disposal of unused or out of date medications. Practices observed reflected this policy.

Inspectors reviewed medication management practice and the administration of medication which was in line with An Bord Altranais agus Cnáimhseachais na hÉireann guidance to nurses and midwives.

Inspectors reviewed a number of the prescription and administration sheets and found the prescription charts now reflected the times medications were to administered and these times were reflected on the administration signature sheet. A number of residents required their medicines to be crushed prior to administration and this was documented

at the top of the prescription sheet. The prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.

A record of medications received and returned to and from pharmacy was maintained. The medications that required strict control measures (MDAs) were checked and counted at the end of each shift by two nurses. Inspectors found record keeping was to a high standard in this area and in line with best practice. MDA medication patches were now being stored in line with best practice.

There were systems in place within the centre for reviewing and monitoring medication management practices, including medication management audits that reviewed administration practice during medication rounds, administration records, prescription sheets and storage of medicines within the centre. Medication incidents including medication errors were recorded and being audited by the management team however, there was no recorded evidence of what measures were taken post the audit to prevent further errors occurring and/or improve outcomes for residents'.

Judgment:
Substantially Compliant

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

Findings:
Inspectors cross referenced notifications submitted to the Authority since the last inspection with records of all accidents and incidents recorded in the centre. All reportable accidents and incidents had been notified to the Authorityby the person in charge in a timely manner.

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):
This was the centre's first inspection by the Authority.

Findings:
Inspectors were satisfied that the healthcare needs of residents' were being met. Some improvements were required to ensure timely referrals were made to multidisciplinary team members when requested by the residents general practitioner.

Residents had access to general practitioner (GP) services and a full range of other services was available on referral including speech and language therapy (SALT), dietetic services, physiotherapy and occupational therapy. Chiropody, dental and optical services were also provided. Psychiatry for older persons community services were also been consulted. Inspectors reviewed a sample of residents' records and found that one resident had a delayed referral to a speech and language therapist for no apparent reason.

Nursing assessments, care planning and additional clinical risk assessments were carried out for residents. Residents and/or relatives confirmed they were involved in the development of their care plans. Inspectors found that some care plans including end of life and activity care plans were detailed and resident specific. Others such as resident pressure area care and nutritional care plans contained a lack of resident specific information to guide care required by residents' and were not updated to reflect the residents changing care needs. For example, the nutritional care plan of a resident identified as having weight loss did not reflect the residents' likes or dislikes and did not reflect the recommendations made by the dietitian regarding what to use to fortify the residents' meals. While the evidence was that care delivery was largely in line with evidence based practice for most residents, records did not reflect the this care. Residents at high risk of developing pressure ulcer had two different pressure ulcer risk assessment tools completed, both providing conflicting information regarding the residents risk of developing a pressure ulcer. Pressure ulcer care plans did not reflect the frequency repositioning was required or/and what preventative equipment was being used and/or what the setting should be on these.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
The complaints procedure was on display in the centre.

The person in charge was using a paper based form for the recording of complaints which were reviewed by inspectors, and found to be inclusive of all information required by the regulations. Inspectors noted three formal complaints had been dealt with, records reviewed reflected the outcome of the complaint and the complainants level of satisfaction level with the outcome records also reflected learning gained and any changes needed following these investigations.

Inspectors were told that "informal complaints" were logged on the computerised system. However, inspectors saw that these were not being recorded on either of the two floors of the centre. Inspectors were concerned that this method did not provide for the person in charge to observe patterns of issues being raised, or ensuring learning and improvements as a result of "informal complaints". It was also not ensuring records were being maintained as required by Schedule 4 of the regulations.

The policy required review to ensure it reflected the person nominated to oversee the management of complaints.

Judgment:
Substantially Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
Inspectors observed lunch time service the dining rooms. Residents spoken with told inspectors they enjoyed the food and the choices available to them.

Dining areas were appropriately furnished and welcoming. Inspectors saw table settings were pleasant, included condiments, napkins and appropriate place settings for all residents. The atmosphere was calm with music playing softly in the background. Residents were offered a choice at lunch time and they obtained their preferred food and drink. There was good supervision by staff and assistance was offered to residents

and provided to those who required it in both their own room and in the dining room. A variety of snacks, hot and cold drinks were offered to residents' between meals.

There was a policy in place to guide and inform staff on the procedures to ensure residents' nutritional and hydration needs were met. Residents' nutritional status were monitored closely. Documentation reviewed showed that each resident's weight was checked on a monthly basis and/or more regularly if required. Nutrition assessments were used to identify residents at risk and care plan reflected their nutritional care needs. Those at risk were referred to multi disciplinary team members for assessment without delay.

Staff spoken with both catering and care staff had a good knowledge of residents' nutritional needs. Records held by catering staff reflected residents preferred diet, required diet and consistency.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
There were policies in place to address communication in the centre including the communication needs of residents'. Inspectors saw residents were facilitated and encouraged to communicate. Staff were observed sitting with a small number of residents' facilitating them to part take in an activity such as knitting, reading the papers or just chatting with them.

A programme of activities was in place and displayed throughout the centre. Residents spoken with were satisfied with the variety and confirmed that they were given the choice to take part or not. There were also specific activity sessions targeted towards residents with dementia where personal acknowledgement, sensory and music prompts were used to help their recollections and memory recall, including memory boxes outside their bedroom. Residents confirmed that they were treated with respect and dignity and said that they felt valued.

Minutes of residents' meetings were available for review. These meetings were

facilitated by an external facilitator, the person in charge was sent a copy of the minutes and she followed up on any required actions prior to the next meeting. Residents confirmed that they were treated with respect and dignity and said that they felt valued. They told inspectors they were facilitated to vote within the centre and their religious needs were met.

Inspectors observed that residents knew the person in charge by her first name and they were aware she had just returned from leave.

Judgment:
Compliant

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

Theme:
Workforce

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

Findings:
There were sufficient numbers of staff with the right skills, qualifications and experience to meet the assessed needs of the residents in the centre at the time of this inspection.

The person in charge informed inspectors that they had actively recruited to fill vacant staff nurses posts. Seven pre- registration student who had completed staff nurse training were working as a health care assistant while awaiting registration with Bord Altranais agus Cnáimhseachais na hÉireann. Inspectors were informed that once these staff were registered the centre would have a full complement of staff.

There was an actual and planned staff rota, these rosters reflected the name and role of each staff member on duty.

Records submitted and reviewed post the inspection confirmed that most staff had mandatory education and training in place. Those who did not were booked to attend planned refresher within the next two months. Staff had also been provided with in-house education on a variety of topics, such as, food hygiene and infection control.

Staff meetings were been held and minutes of these meetings were available for review. The management team had sourced a revised appraisal template for staff appraisals in

2016, they had begun the process however, these were not reviewed on this inspection. A sample of staff files reviewed contained all the required documents.
Judgment: Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Beneavin Lodge Nursing Home
Centre ID:	OSV-0000117
Date of inspection:	16/05/2016
Date of response:	21/06/2016

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The annual review did not reflect evidence of consultation with residents and their representatives.

1. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

Please state the actions you have taken or are planning to take:
Consultation had taken place with the residents and families but had not been included/reflected in the Annual Report. This engagement between Beneavin Lodge, residents and families will be included in the report

Proposed Timescale: 15/07/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Audits conducted to date did not clearly identify what was being done with the audit results to ensure improved outcomes for residents.

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

Please state the actions you have taken or are planning to take:
The audits used within Beneavin Lodge will be reviewed and amended to ensure the audit process is clear and complete. The audits will include a section to reflect learning lessons, actions completed, and the trends that have been established. These audits will now have to be signed off monthly by the Operations Manager to ensure the process has been completed and the appropriate actions have been taken.

Proposed Timescale: 31/07/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans of some residents' who displayed behaviours that challenge were not reflective of the residents' triggers and did not reflect their de-escalation plan.

3. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
All care plans relating to challenging behaviours will be reviewed by the PIC in the

home to ensure all known triggers are clearly recorded and evident to staff. Nurses in the Nursing Home will receive further training in relation to the recording of these details in a challenging behaviour care plan.

Proposed Timescale: 30/08/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Alternatives trialled, tested and failed were not reflected on each residents' restraint assessment forms.

4. 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:
The restraint policy will be reviewed and the assessment tool updated to ensure that all alternatives trialled are indicated and recorded appropriately. The assessment tool will also highlight where alternatives were trialled but were unsuccessful and will clearly record all decisions relating to the use of the restraint.

Proposed Timescale: 15/08/2016

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:
A number of residents required their medicines to be crushed prior to administration and this was documented at the top of the prescription sheet. The prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.

Medication error records did not reflect what measures were taken to prevent a repeat of errors and/or improve outcomes for residents'.

5. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
The Nursing Home Prescription will be amended to ensure all crushing orders are authorised for each individual medication prescribed. (June 24th, 2016). The medication error form will be amended to include a section for completion by the Home Manager which reflects the learning lessons, actions taken and measures put in place to ensure the risk of error is reduced/minimised. (June 30th, 2016).

Proposed Timescale: 24/06/2016

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:
Assessments for pressure ulcer care provided conflicting information.

Care plans were not being updated to reflect recommendations made by visiting inter disciplinary team members.

6. 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:
All Nursing Staff will receive refresher training on the care planning process. The Home Manager will review all new admissions 48 hours post admission, to ensure compliance with FirstCare Policy. The named nurse system is in place in Beneavin Lodge which will enable to Home Manager to identify which nursing staff require additional support with admissions and care planning through training and mentoring.

Proposed Timescale: 18/07/2016

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:
Verbal/informal complaints were not being properly recorded and the results of any investigations into the matters complained of and any actions taken on foot of a complaint were not recorded.

7. Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:
Post inspection a Compliments/Complaints/Concerns record will be available on each floor so that individuals in each area of the home have the ability to log satisfaction/concerns immediately without having to seek out the Home Manager or one of the Clinical Nurse Managers. The Home Manager (or designated other) will review the record weekly, and follow up on any issues of concern ensuring all respondents are aware of the Compliments/Complaints and appeals procedure where necessary. The FirstCare Policy will be updated to reflect this change.

Proposed Timescale: 31/07/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person nominated to oversee the complaints process was not reflected in the complaints process.

8. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
FirstCare will review the Complaints Procedure to ensure that the Compliance and Quality Manager reviews the complaints on a bi-monthly basis to ensure compliance with the FirstCare policy. This will enable us to audit all complaints/concerns and to ensure the complaints process is completed appropriately and satisfaction is recorded. The review of each complaint will also enable us to oversee the complaints process and recognise if trends have developed in relation to complaints, and/or if issues that arise are being appropriately addressed and learning is taking place.

Proposed Timescale: 15/07/2016