

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Rushmore Nursing Home
Centre ID:	OSV-0000381
Centre address:	Knocknacarra, Galway.
Telephone number:	091 523 257
Email address:	rushmorenursinghome@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Rushmany Nursing Home Limited
Provider Nominee:	Sharon Conlon
Lead inspector:	PJ Wynne
Support inspector(s):	Shane Grogan
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 27 April 2016 10:00 To: 27 April 2016 19:50

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

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

Summary of findings from this inspection

This report set out the findings of an unannounced monitoring inspection. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

There were 19 residents accommodated at the time of this inspection. All residents except one were accommodated for long-term care. The remaining resident was admitted for a period of convalescent care. The provider is registered to accommodate a maximum of 27 residents. Due to structural work on going at the centre, the provider has reduced maximum occupancy to 19 residents.

The person in charge has changed since the last inspection. The required notification was submitted to HIQA in February 2015. The person in charge appointed fulfils the criteria required by the regulations in terms of qualifications and experience.

A total of nine Outcomes were inspected. The inspector judged one Outcome as major non-compliant and five Outcomes as moderately non-compliant. Two Outcomes were judged as substantially in compliance with the regulations. One Outcome was

fully compliant.

The areas of moderate non-compliance primarily related to;

Reviewing the governance arrangements in place to ensure the service provided is safe, appropriate and consistent.

Aspects of fire safety and risk management require review considering the construction works being undertaken in the premises.

In some cases, residents had variable access to general practitioner services.

The deployment of care staff and assignment of work practices requires review.

Further work is required to develop care plans that are more person-centered and individualised for each resident.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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):

No actions were required from the previous inspection.

Findings:

There was a defined management structure in place with which staff were familiar. The governance arrangements in place require review to ensure the service provided is safe, appropriate and consistent.

The management team have a visible presence at all levels throughout the centre. The registered provider is actively involved in the centre and she is well known to residents and their families. However, in accordance with regulation 6 (1) and (2), timely medical assessment and regular clinical reviews did not always occur.

It was identified a collective review to inform learning in safeguarding vulnerable adults was required.

The governance arrangements to manage aspects of fire safety and risk management require review considering the construction works being undertaken

Records required by the regulations were suitably and securely maintained and kept up to date.

Staff had undertaken appropriate training within suitable timeframes to include refresher updates as required by the regulations.

Judgment:

Non Compliant - Moderate

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

<i>the service.</i>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The person in charge has changed since the last inspection. HIQA received a notification of a change of person in charge in February 2015. The person in charge is a registered nurse and is noted on the roster as working in the post full-time.</p> <p>The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. The nominated person to fulfil the role of the person in charge has more than three years experience of nursing older persons within the last six years as required by the regulations.</p> <p>The person in charge has maintained her professional development and attended mandatory training required by the regulations. The person in charge facilitated the inspection well and provided all information requested by the inspectors.</p> <p>She was well known by residents. She had good knowledge of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 05: Documentation to be kept at a designated centre</i> <i>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.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings:</p>

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

A sample of four staff files were examined to assess the documentation available, in respect of persons employed. The information required by Schedule 2 of the regulations was available in the staff files reviewed.

The certificate of registration was not displayed prominently as required by the regulations. It was displayed in the nurse's office and not clearly visible to residents and visitors to the centre.

A directory of residents' was maintained and available for review. The directory contained the facility to record all the information required by Schedule 3, of the regulations. The directory was not accurately maintained up to date. The details of admission of one resident were not recorded in the directory.

Judgment:

Substantially Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Staff training, supervisions and appraisals were completed. Staff had the knowledge, skills and experience they needed to carry out their roles.

All staff spoken with were able to explain the different types of abuse, signs to look out for and how to report any concerns. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming there was an ongoing program of refresher training in protection of vulnerable adults.

Four notifiable adult protection incidents, which are a statutory reporting requirement to HIQA, have been reported since the last inspection. The person in charge and provider investigated each incident. Appropriate action to safeguard the well-being of residents was undertaken in each case. However, the management team had not completed a collective review to include a root cause analysis to inform learning in safeguarding vulnerable adults. The safeguarding training content, its implementation in practice and understanding by staff was not reviewed in conjunction with the policy on adult protection to inform learning for both management and staff.

There is a policy on the management of responsive behaviours. Staff spoken with were familiar with resident's behaviours and could describe particular residents' daily routines very well to the inspectors.

Staff have participated in training in caring for residents with responsive behaviours. The training was undertaken on the same day as refresher training in protection of vulnerable adults.

There was evidence when residents had specialist care needs such as mental health difficulties, of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health. The community mental health nurse visits the centre to provide specialist advice to support care to residents.

Care plans for residents with responsive behaviours require review. The care plan for one resident with an acute mental health problem was examined. The care plan was revised on return from a hospital admission to a psychiatric unit. However, the interventions outlined were generic for example, 'help to readjust to living in the centre'. The plan of care to meet the psychosocial needs of the resident was not linked to the resident's life history. The plan of care did not detail known triggers and outline preventative and reactive strategies to include the impact of medication prescribed by the mental health team.

There was a policy on restraint management (the use of bedrails and lap belts) in place. A restraint free environment was being promoted. At the time of this inspection there were five residents with their bedrails raised.

A risk assessment was completed prior to using bedrails. However, the assessment tool took cognisance only of a limited range of issues. Risk from behaviour, intermittent confusion or medical conditions were not explored. There was limited evidence of exploring alternative options prior to using a restraint measures in the documentation reviewed such as ultra low beds, perimeter mattresses or additional mattress by the bed or increased safety checks. The rationale why alternative measures trialled were unsuccessful was not outlined. There was minimal evidence of multi disciplinary input in the decision making process. In files reviewed where residents requested the bedrails raised as an enabler, the enabling function was not clearly evident. The documentation did not outline the enabling function for example, if it helped the resident to sit up or turn in bed unaided.

The inspector examined the financial controls in place to ensure the safeguarding of residents' finances. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. A petty cash system was in place to manage small amounts of personal money for residents. A record of the handling of money was maintained for each transaction. Two signatures were recorded for each transaction.

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 governance arrangements to manage risk situations were specified. While there were procedures in relation to self harm, violence and aggression they were not linked or referenced to the risk management policy as required by the regulation 26 and schedule 5 to guide staff.

Responsibility for health and safety procedures and an organisational safety structure was outlined in the health and safety statement. However, aspects of fire safety and risk management require review considering the construction works being undertaken in the premises.

Two of the four designated final fire exit were not accessible on the day of inspection. One exit door did not have a handle and the area outside the fire door was not clear. The second exit door was not openable in the event of an emergency and was not connected to the fire alarm system. The fire action notices displayed on the wall indicated both doors were designated operational fire escape routes.

The arrangements for the appropriate maintenance of fire safety systems such as the fire detection and alarm system require review. The fire alarm and emergency lighting was not serviced at quarterly intervals throughout the year by a competent person in accordance with fire safety standards.

The evacuation needs of residents had not been assessed. Personal emergency evacuation plans were not developed for residents detailing both their day and night evacuation requirements.

There was an ongoing program of refresher training in fire safety evacuation. Records indicated fire drill practices were completed. The fire drill records detailed the scenario or type of simulated practice, to include the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario. There was evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

A sufficient number of cleaning staff were rostered each day of the week. Colour coded cleaning equipment and cloths were provided to clean bedrooms and communal areas. A new sluice room has been constructed. The equipment provided had not been fully installed and made available for use. Presently a bathroom is used to sluice equipment

and material. A risk assessment for this practice was not undertaken to minimise the risk of cross infection until the new sluice room is operational.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near miss event were documented in an accident log. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury. However, post incident reviews were completed to identify any contributing factors for example, recent infection or the impact of changes to medication.

The training records showed that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents' needs. Moving and handling risk assessments were completed for each resident. The type of hoist was specified where required. However, the sling size required by the residents was not specified in all moving and handling assessments reviewed.

There was a contract in place to ensure hoists and other equipment to include electric beds and air mattresses used by residents was serviced and checked by qualified personnel to ensure they were functioning safely.

Hand testing indicated the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds.

Judgment:

Non Compliant - Moderate

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):

Findings:

There was a medication management policy in place, which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

Each resident's medication was dispensed from individual packs. These were delivered by the pharmacy and contained a two-week supply of each resident's medication. A tray was provided in the medication trolley to store each resident's individual medication.

The inspector reviewed a sample of drugs charts. Photographic identification was not

available on the prescription chart for each resident to ensure the correct identity of the resident receiving the medication. One resident did not have photographic identification on the prescription sheet or tray containing their medication in the drugs trolley.

The prescription sheets reviewed were legible in all cases. Medications were transcribed by nursing staff. Transcribed medications were countersigned by a second in each of the sample of prescriptions examined in accordance with An Bord Altranais guidance on medication management. The maximum amount for (PRN) medication (a medicine only taken as the need arises) was indicated on the prescription sheets examined.

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

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

Findings:

There were 19 residents in the centre during the inspection. There were eight residents with high dependency care needs. Seven had medium dependency care needs and four residents were considered as low dependency. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition.

Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and continence needs. However,

the risk assessments were not recompleted on a new page at regular intervals. It was difficult to track the most recent reassessment and the action required from the assessment completed. One resident's dependency levels, the risk of developing pressure sores and falls risk were recompleted on the same page of the assessment tool since admission to the centre five years previously.

The inspector reviewed three resident's care plans in detail and certain aspects within other plans of care. In the majority of care plans reviewed there were plans of care developed for all care needs identified. On admission, a comprehensive assessment of needs was completed. Care plans were updated at the required intervals. There was evidence of consultation with residents or their representative in care plans.

However, there was poor linkage between assessments completed, care plans developed and reviews. Further work is required to develop care plans that are more person-centred and individualised for each resident. Some of the care interventions described were generic. A personal hygiene care plan was not updated to reflect the changing needs of residents. A review by the physiotherapist for one resident was not supported with a plan of care to meet identified needs. A review by the dietician resulting in changes to nutritional supplements was not updated in the plan of care.

End of life care plans were not well developed to detail personal and spiritual wishes. Decisions concerning future healthcare interventions were not outlined. Resident's preferences with regard to transfer to hospital if of a therapeutic benefit were not documented in end-of -life care plans.

Access to allied health professionals to include physiotherapy, speech and language therapist and dietetic services were available. Where residents had specialist care needs such as mental health problems there was evidence in medical files of good links with the mental health services. The psychiatry team visit the centre as required to review residents. Medication was reviewed to ensure optimum therapeutic values.

Some residents had variable access to general practitioner (GP) services. In accordance with regulation 6 (1) and (2), timely medical assessment and regular clinical reviews did not always occur. There was evidence in some cases of a reliance on faxed advice or prescriptions by the person in charge. One resident admitted to the centre from hospital at the beginning of January 2016 was not reviewed by the GP in the centre since admission. Changes were made to the resident's medication to include the prescribing of an anti-anxiety medication.

There was one resident with a vascular wound at the time of this inspection. The inspector saw the care plan, wound dressing records and comments on progress were available and that the wound was indicating signs of improvement. Specialist advice from the vascular clinic was obtained and the resident was reviewed at regular intervals. Nutritional supplements to aid healing were included in the resident's diet.

Nutritional screening was carried out using an evidence-based screening tool. There was a good dietary intake observed by the inspector at mealtimes by the residents. There was a choice of a variety of nutritious wholesome food provided. The policy of the centre is all residents are to be weighed at a minimum on a monthly basis. However,

there were gaps in the records, as a small number of residents were not weighed consecutively each month. One resident did not have any weight checks recorded for a three-month period.

Social care assessments were not completed for each resident. This was an area of improvement identified in the action plan of the previous inspection report. While some assessments were completed they contained limited information and did not fully inform the activity program to meet the interest and capacities of individual residents.

Judgment:
Non Compliant - Major

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:
No complaints were being investigated at the time of inspection. A complaints log was in place, which contained the facility to record all relevant information about complaints.

The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

The complaints procedure was displayed and a comments box was provided to obtain views on the service provided.

Aspects of the complaints procedure require review. The role of the advocate requires review to ensure clarity within the complaint procedures to ensure clear understanding, the advocate role is to help residents raise any issue or concerns they may have.

The independent appeals process if the complainant was not satisfied with the outcome of their complaint by the person nominated to investigate complaints was not fully meeting the requirements of the regulations. The contact details of the Office of the Ombudsman were not outlined in the appeals procedures.

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):

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

Findings:

The inspector found there was an adequate complement of staff with the proper skills and experience on each work shift to meet the assessed needs of residents at the time of this inspection, taking into account of the purpose and size of the designated centre.

However, the deployment of care staff and assignment of work practices requires review. Care staff had dual roles and assisted with laundry and activities with residents during the day. It was observed at mealtimes there was an insufficient number of care staff present at lunchtime to assist those requiring help with their meals. One care staff assisted two residents, while another resident had his lunch placed beside him but had to wait for a prolonged period to be assisted.

Staff training was facilitated and updates were completed by staff. The inspector evidenced that in addition to mandatory training required by the regulations staff had attended training in medication management, end of life care and hand hygiene.

Staff received regular supervisions appraisals which were documented in their files. Staff told the inspector that they felt well supported by the registered provider and person in charge.

The majority of staff had received training in responsive behaviours. However, training in caring for older people with cognitive impairment or dementia had not been completed by staff. Eight of the 19 residents accommodated had a diagnosis of dementia, cognitive impairment or Alzheimer's.

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:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Rushmore Nursing Home
Centre ID:	OSV-0000381
Date of inspection:	27/04/2016
Date of response:	07/06/2016

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:

In accordance with regulation 6 (1) and (2), timely medical assessment and regular clinical reviews did not always occur. A collective review to inform learning in safeguarding vulnerable adults was identified.

The governance arrangements to manage aspects of fire safety and risk management require review considering the construction works being undertaken.

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 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:

In order to ensure a timely medical assessment and regular clinical reviews a more robust system for admission is now in place

- Admission check list & follow up procedure

Fire safety & risk management

- There has been a reviewed assessment completed that considers the construction works being undertaken

Proposed Timescale: 29/04/2016

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:

The directory was not accurately maintained up to date. The details of admission of one resident were not recorded in the directory.

2. Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

Admission directory now includes resident admission details previously not recorded

Proposed Timescale: 28/04/2016

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The certificate of registration was not displayed prominently as required by the regulations.

3. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

The certificate of registration is now displayed in a prominent place

Proposed Timescale: 28/04/2016

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:

The restraint assessment tool took cognisance only of a limited range of issues. Risk from behaviour, intermittent confusion or medical conditions were not explored.

There was limited evidence of exploring alternative options prior to using a restraint measures in the documentation reviewed such as ultra low beds, perimeter mattresses or additional mattress by the bed or increased safety checks.

The rationale why alternative measures trialled were unsuccessful was not outlined.

There was minimal evidence of multi disciplinary input in the decision making process.

In files reviewed where residents requested the bedrails raised as an enabler, the enabling function was not clearly evident. The documentation did not outline the enabling function for example, if it helped the resident to sit up or turn in bed unaided.

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:

There is now in place a revised restraint Assessment document that covers a varied & comprehensive range of issues, risks, choices and outcomes pertaining to restraint.

Proposed Timescale: 02/06/2016

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:

Post incident reviews were not completed to identify any contributing factors for example, recent infection or changes to medication.

The sling size required by the residents was not specified in all assessments reviewed.

5. 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:

Post incident reviews are now in place in order to identify any contributing factors for example, recent infection or changes to medication

Slings shall be included in all assessments/care plans

Proposed Timescale: 28/04/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Presently a bathroom is used to sluice equipment and material. A risk assessment for this practice was not undertaken to minimise the risk of cross infection until the new sluice room is operational.

6. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

The new sluice room is now operational

Proposed Timescale: 02/06/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Two of the four designated final fire exit were not accessible on the day of inspection. One exit door did not have a handle and the area outside the fire door was not clear. The second exit door was not readily openable in the event of an emergency and was not connected to the fire alarm system.

7. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

Both doors are now readily openable
Outside area is clear
the doors are not connected to the fire alarm system as they open freely and are not locked from within

Proposed Timescale:

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The fire alarm and emergency lighting was not serviced at quarterly intervals throughout the year by a competent person in accordance with fire safety standards.

8. 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 fire alarm & emergency lighting have been under constant supervision from an electrical contractor for the last year as the system is in the process of being upgraded. A certificate is available

Proposed Timescale:

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Personal emergency evacuation plans were not developed for residents detailing both their day and night evacuation requirements.

9. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

Evacuation plans for each resident are in process

Proposed Timescale: 15/07/2016

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:

One resident did not have photographic identification on the prescription sheet or tray containing their medication in the drugs trolley.

10. 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:

All resident's now have photographic identification on the prescription sheet or tray containing their medication in the drugs trolley

Proposed Timescale: 03/06/2016

Outcome 11: Health and Social Care Needs**Theme:**

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was poor linkage between assessments completed, care plans developed and reviews. Further work is required to develop care plans that are more person-centred and individualised for each resident. Some of the care interventions described were generic.

The risk assessments were not recompleted on a new page at regular intervals. It was difficult to track the most recent reassessment and the action required from the assessment completed. One resident's dependency levels, the risk of developing pressure sores and falls risk were recompleted on the same page of the assessment tool since admission to the centre five years previously.

A personal hygiene care plan was not updated to reflect the changing needs of a residents.

A review by the physiotherapist for one resident was not supported with the a plan of care to meet identified needs.

A review by the dietician resulting in changes to nutritional supplements was not updated in the plan of care.

Care plans for residents with responsive behaviours require review. The interventions

outlined were generic for example, 'help to readjust to living in the centre. The plan of care did not detail known triggers and outline preventative and reactive strategies.

Social care assessments were not completed for each resident.

11. Action Required:

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

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

All Care plans have been reviewed to be more person centred, to capture all requirements/up-dates – to include physio therapy & dietician, also triggers & outline preventative and reactive strategies

Social care assessments will be updated/completed

Proposed Timescale: 31/07/2016

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Some residents had variable access to general practitioner (GP) services. In accordance with regulation 6 (1) and (2), timely medical assessment and regular clinical reviews did not always occur.

There were gaps in weight records as a small number of residents were not weighed consecutively each month. One resident did not have any weight checks recorded for a three month period.

12. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

In order to ensure a timely medical assessment and regular clinical reviews a more robust system for admission is now in place

- Admission check list & follow up procedure

All residents shall be weighed monthly

Proposed Timescale:

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:

The role of the advocate requires review to ensure clarity within the complaint procedures to ensure clear understanding, the advocate role is to help residents raise any issue or concerns they may have.

13. Action Required:

Under Regulation 34(1)(e) you are required to: Assist a complainant to understand the complaints procedure.

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

The complaint's procedure includes clarity as to a clear understanding, as to the role of the advocate and of how they may help residents to raise matters of concern

Proposed Timescale: 19/05/2016

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The contact details of the Office of the Ombudsman were not outlined in the appeals procedures.

14. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

The contact details of the Office of the Ombudsman are now outlined in the appeals procedures

Proposed Timescale: 19/05/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The deployment of care staff and assignment of work practices requires review. Care staff had dual roles and assisted with laundry and activities with residents during the day. It was observed at mealtimes there was an insufficient number of care staff present at lunch time to assist those requiring help with their meals.

15. 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 deployment of care staff and assignment of work practices shall be reviewed more thoroughly once the building work has been completed however The strategy at meal times was immediately changed to ensure a sufficient number of care staff are present to assist those requiring help with their meals

Proposed Timescale: 02/08/2016

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Training in caring for older people with cognitive impairment or dementia had not been completed by staff.

16. 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:

All staff have been instructed to complete a specific training in cognitive impairment or dementia

Proposed Timescale: 15/07/2016