

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Lawson House Nursing Home
Centre ID:	OSV-0000244
Centre address:	Knockrathkyle, Glenbrien, Enniscorthy, Wexford.
Telephone number:	053 923 3945
Email address:	info@lawsonhouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Lawson House Nursing Home Limited
Provider Nominee:	Christine Brett Moroz
Lead inspector:	Ide Cronin
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	55
Number of vacancies on the date of inspection:	9

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From: 28 September 2016 10:15 To: 28 September 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	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Non Compliant - Moderate
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 - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The previous inspection of the centre was in February 2016. Major non-compliances were found relating to governance and management, and moderate non-compliances were identified in relation to safeguarding, health and social care needs, supervision, staffing, premises and residents' rights, dignity and consultation. Due to the nature of the findings and the number of non-compliances found on the previous inspection the provider was advised that no new residents should be admitted to the centre until the staffing levels and skill mix were sufficient to meet the needs of residents. Inspectors acknowledge that the provider had already ceased admissions to the centre prior to inspection due to inadequate staffing levels.

Although some progress was made by the provider in implementing the required improvements identified on the thematic inspection in February 2016, some of the findings at that time were again evident on this inspection. The inspector acknowledges that improvements had been made to the premises. However, nine actions out of 17 from the previous inspection had not been completed within the agreed timeframes. Since the previous inspection a number of nursing posts had not been filled, which resulted in the person in charge and nurses working many additional hours which was unsustainable. In addition the person in charge was unable to devote the required time to her role as provider and person in charge.

The inspector found that the person in charge who was also the provider nominee did not have the capacity to have robust oversight of the centre to ensure that safe effective care was provided to residents. This was due to her spending considerable time delivering nursing care and this impacted on her ability to effectively fulfil her managerial role. Clinical audit and systems in place for reviewing quality and safety of care had not progressed to a satisfactory standard.

Staff rosters were reviewed and the inspector found that there were some weeks that the person in charge worked in excess of 72 hours, which is in excess of the working time act. The week following inspection the person in charge was to resume normal working hours as the nursing posts had been filled and nursing staff had completed their induction. On the day of inspection the person in charge was working within the staff compliment as she was supervising two recently recruited nurses from overseas.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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.

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):

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

Findings:

The inspector found that there was an organisational structure in place. However, significant improvements regarding management systems were required to ensure compliance with the Regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed ensuring residents were being delivered a service that was safe, effective and met their needs.

The inspector found that nine actions out of 17 from the previous inspection had not been completed within the agreed timeframes.

Thirteen regulatory non compliances were found on this inspection. Seven of which were the responsibility of the provider. Six were the responsibility of the person in charge.

The provider is also the person in charge of the centre. She is supported in her role by a senior staff nurse, a company director/services manager and an accountant. On the previous inspection it was found that the clinical management structure was not adequately resourced and was not defined in terms of roles, responsibility and clear lines of authority and accountability. The provider/person in charge was frequently part of the care team and was unable to devote the time required to fulfil her managerial role. This remained the same on the day of this inspection.

The duty roster evidenced that senior clinical staff including the person in charge worked in excess of standard full-time working hours on a consistent basis. The inspector saw that the person in charge had recently worked 121 hours over a ten day period without a day off. Deputising arrangements for absences of the person in charge were not clear. The person in charge said that she had not taken any annual leave.

The inspector found that the system in place to monitor the quality and safety of care

and the quality of life for residents required substantial improvement. The inspector observed that the only aspect of clinical care that had been audited since the previous inspection was medication management. As on the previous inspection resident falls were recorded appropriately but trends were not reviewed to ensure the resources provided supported the safety needs of residents at risk of falling.

The information available in relation to falls did identify deficits in practice. However, there was no evidence that the information collated positively informed improvements in the safety and quality of care or the quality of life of residents. An annual review of the Quality of the Service for 2015 was available.

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 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 held the post at the last inspection and she worked full-time in this role. She provided clinical leadership to the staff team. She was suitably qualified as a registered nurse and had the authority accountability and responsibility for the provision of the service. The person in charge and the staff team facilitated this inspection and were knowledgeable of residents' care and conditions. Staff confirmed that improved and good communications exist within the staff team and management group.

However the inspector found that on the previous inspection seven of the 17 non compliances found were the regulatory responsibility of the person in charge. Four of these non compliances were again found on this inspection. Six action plans relate to failures of the person in charge to meet the regulatory requirements. A judgment of moderate non compliance was made based on these findings. The related action plans are under the governance and management Outcome.

Judgment:
Non Compliant - Moderate

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):

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

Findings:

The inspector found that measures were in place to protect residents from being harmed or abused. The centre was safe and secure with administrative staff on duty to assist in the monitoring of visitors in and out of the centre. A record of all visitors to the centre was maintained.

The inspector viewed training records and saw that all staff had received training on identifying and responding to elder abuse. Staff who spoke with the inspector were able to identify the different categories of abuse and what their responsibilities were if they suspected abuse or were uncomfortable with how a resident was being treated.

The inspector found that the use of restraint was risk assessed and records were maintained of the type of restraints or enablers in place. Each resident requiring restraint had a restraint care plan and a restraint assessment form had also been completed. On each assessment seen, the least restrictive alternative to the use of restraint had been considered and the reason for the restraint was discussed with the resident, family and GP. Checks were in place for the use of restraint and the inspector saw that these were recorded. The inspector saw that the use of bed rails had decreased since the previous inspection. Equipment such as low beds and floor (crash) mats had been used as an alternative prior to bedrails.

Inspectors saw that expert advice from the relevant professionals was sought where necessary before commencing any psychotropic medication or any use of physical restraint. There was no chemical restraint used on a p.r.n (as required basis) as observed by the inspector.

On the previous inspection it was identified that there was no standardised assessment tool to assess behaviours. Clear strategies were not outlined to support a consistent approach to the management of behaviours that challenge or that focussed on a proactive and positive approach. This remains the same and this action was not completed on the day of inspection.

A review of training records indicated that only 25 staff out of a complement of 62 were provided with up-to-date knowledge and skills, appropriate to their role to enable them to manage and respond to behaviour that is challenging which is a requirement of legislation. The inspector was informed that this was scheduled in October even though the action plan response from the previous inspection indicated that it would be

completed by July 2016. Therefore this action remains outstanding from the previous inspection. The person in charge said that there were no residents displaying behaviours that challenge.

The management of residents' finances was not reviewed on this inspection as this line of enquiry was reviewed and found to be managed well during the previous inspection.

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:

A risk management policy and a health and safety statement were available. The risk management policy did not include the arrangements for the identification, recording, investigation and learning from serious incidents. Policies were also available to provide guidance to staff on specific areas required by the legislation including the risks of absconding, assault, self harm, accidental injury and behaviours that challenge.

Measures were in place to prevent accidents in the centre and within the grounds. A fire safety register and associated records were maintained and precautions against the risk of fire were in place. Service records confirmed that the fire alarm system and fire safety equipment including emergency lighting and extinguishers were serviced appropriately and serviced on a regular basis.

Directional signage was visible in prominent places. Means of escape and fire exits were unobstructed as observed by inspector. Staff were trained in fire safety and those who spoke with the inspector knew what to do in the event of a fire. Records reviewed showed that this training included practicing a mock fire drill with evacuation times recorded. However, records did not evidence simulated fire drills were undertaken to reflect a night time situation when staffing levels are reduced. There was no evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

A policy on infection control was provided and appropriate measures were in place to control and prevent infection including supplies of hand sanitising gel. However, there was no emergency plan in place which would identify what to do in the event of emergencies including loss of power and flooding. The plan should also include evacuation procedures, transport arrangements and emergency accommodation. The

inspector was informed that there was a plan but it was not made available to the inspector on the day of inspection nor was it furnished following inspection as requested by the inspector. There were arrangements in place for recording and investigating untoward incidents and accidents. However, as outlined under Outcome 1 the inspector noted that falls and near misses were described but deficits were not actioned.

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):

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

Findings:

The inspector reviewed the practices and documentation in place relating to medication management in the centre. There were written policies in place relating to the ordering, prescribing, storing and administration of medicines to residents. There were procedures in place for the handling and disposal of unused and out of date medicines.

All medicines were stored securely in the centre. However there were a number of issues relating to the prescribing and administration documentation that required improvement to ensure medication management practice was to an appropriate standard.

The inspector reviewed a number of the prescription and administration sheets and identified issues that did not conform with appropriate medication management practice:

- Red ink was used in charts viewed by the inspector which is not in accordance with best practice in medication management
- there were gaps identified in a sample of the medication administration records reviewed, therefore it was impossible to ascertain if the medicines had been given to the resident or not
- it was observed that not all medications were individually prescribed by the prescriber which is not in accordance with best practice.

There was adequate and secure storage for medication, with medication requiring refrigeration stored appropriately, and monitored daily. Controlled drugs were stored

and managed in accordance with legislative requirements and a register of these medicines was maintained with the stock balances checked and signed by two nurses at the end of each working shift.

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre on a regular basis, conducting reviews of residents' medications and medication audits.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The inspector found that an adequate standard of personal care and appropriate medical and allied health care access was in place. There was evidence that timely access to health care services was facilitated for all residents. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition. Residents had access to GP services and out-of-hours medical cover was provided. Psychiatry of later life services were available to the residents. A full range of other services was available on referral including speech and language therapy (SALT), physiotherapy services and occupational therapy (OT) services. Chiropody, dental and optical services were also provided.

A computerised resident information management system was in place. A sample of residents' care plans were reviewed via the computerised documentation system. Residents' had a comprehensive assessment completed on admission and these were reviewed on a three monthly basis. However, each need identified on assessment did not always have a corresponding care plan in place to reflect this need. This was also identified on the previous inspection.

Nursing staff completed daily progress entries. Care staff populated residents' documentation records with care activities completed by them by means of wall-

mounted electronic data pad units located throughout the centre. All residents' electronic records were password protected as observed by the inspector.

Arrangements were in place where care plans were reviewed and updated on a regular basis by staff. The inspector was told that residents or their next of kin were involved in the care planning review process. However, this was not consistently documented in residents' care plans. This was also a finding on the previous inspection.

There was an end-of-life care policy detailing procedures to guide staff. The policy in the centre is that all residents are for resuscitation unless documented otherwise. Care plans were found to reference the religious needs, social and spiritual needs of each resident. Individual religious and cultural practices were facilitated.

While end of life care needs were identified on admission and updated accordingly there was inconsistent evidence of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell. Decisions concerning future healthcare interventions required review. Resident's preferences with regard to transfer to hospital if of a therapeutic benefit were not documented in any of the end-of -life care plans reviewed by the inspector. This was also a finding on the previous inspection.

There was evidence in medical records that end-of life care decisions regarding resuscitation were documented. However, as on the previous inspection there was inconsistent evidence of discussion or input from residents or relatives on the record or on a separate consent form to confirm this decision.

There were two activities coordinators and an activity assistant employed over a seven day period. The activity co-ordinator spoke with the inspector and was well informed. She understood the needs of residents with cognitive impairment and was creative to ensure residents were provided with activities that met their interests and capabilities.

Residents were seen enjoying various activities during the inspection. Each resident's preferences were assessed and this information was used to plan the activity programme. A programme of events was displayed and included religious ceremonies, bingo and music on a weekly basis. A range of both group and individual activities was available. The inspector saw that day trips also took place.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

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

Findings:

Only the components of the previous action plan were reviewed in relation to premises on this inspection. On the previous inspection it was found that aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia. It was also found that the doors were secured to the garden and inspectors were told it was not available to residents during the winter months.

On this inspection the inspector observed that the doors were open into a secure garden area for residents. A gazebo had been erected and staff told the inspector that residents loved being out there and had made great use of it in the summer months.

The inspector saw that a sensory room had been developed. The activity coordinator said that this room was a great asset for some residents. There was also now a cinema room and an additional family room for residents. On the previous inspection the entrance doors to the resident accommodation areas were secured. Access required residents to co-ordinate pressing a release button and manually opening the doors. This negatively impacted on their independent access around the centre. On this inspection the inspector observed that the key pads had been removed therefore residents could independently access their rooms.

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):

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

Findings:

On the previous inspection it was found that nine whole time equivalent staff nurse posts were vacant since 2015. On this inspection four nursing whole time equivalent posts had been filled and two nurses had returned from leave. Since the last inspection nursing staff had worked over and above 40 hours per week. When reviewing the rosters the inspector saw that on many occasions due to staff shortages the person in charge replaced nursing staff in direct care provision. The person in charge informed the inspector that from week commencing 3 October 2016 that nursing staff rostered hours would return to normal. This was also evidenced on nursing rosters provided to the inspector.

Systems of communication were in place to support staff with providing safe and appropriate care. There were hand-over meetings each day to ensure good communication and continuity of care when shifts changed. Staff told the inspectors that they became familiar with all residents and their care needs by means of the daily handover and talking to colleagues. The inspector saw evidence of supervision for healthcare staff by a senior healthcare attendant who supervised shifts and arranged for regular staff meetings. On the previous inspection it was found that the person in charge had created a position of senior care assistant to lead and support staff in the provision of care to residents.

The inspector saw records of regular meetings between nursing management at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards. In discussions with staff, they confirmed that they were supported to carry out their work by the provider/ person in charge. The inspector found staff to be well informed and knowledgeable of their roles, responsibilities and the standards regarding residents.

There was a training matrix available which conveyed that staff had access to on going education and a range of training was provided. In addition to mandatory training required by the Regulations staff had attended training on tissue viability, nutrition and stroke care. However, there were no dates on the matrix for this training therefore the inspector could not ascertain when the training had been completed. As identified and actioned under Outcome 7, Safeguarding and Safety, all staff were not trained in the management of behaviours that challenge.

There was a recruitment policy in place and staff recruitment was in line with the Regulations. The person in charge said that all staff were Garda vetted. There were no volunteers working in the centre at the time of this inspection. A checking system was in place to ensure that all documents required by the Regulations were in place. There was an orientation/induction programme for new staff. However, the inspector was not satisfied with the supervision systems in place. The person in charge was frequently replacing nursing staff in direct care provision and staff appraisals were not completed on an annual basis. Therefore the inspector could not ascertain how staff were supported to carry out their duties to protect and promote the care and welfare of all residents.

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:

Ide Cronin
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:	Lawson House Nursing Home
Centre ID:	OSV-0000244
Date of inspection:	28/09/2016
Date of response:	26/10/2016

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 provider/person in charge was frequently part of the care team and was unable to devote the time required to fulfil her managerial role.

1. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and

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

details responsibilities for all areas of service provision.

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

The person in charge is no longer part of the care team since 3 October 2016, we now have a full complement of nursing staff which ensures that no staff are required to work in excess of 39hrs/week. Our governance structure and all job descriptions are under review in consultation with our independent consultants, to provide clearly defined organizational structures.

Proposed Timescale: 26/10/2016

Theme:

Governance, Leadership and Management

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

Nine actions out of 17 from the previous inspection had not been completed within the agreed timeframes.

Thirteen regulatory non compliances were found on this inspection, seven of which were the responsibility of the provider. Six were the responsibility of the person in charge. The inspector observed that the only aspect of clinical care that had been reviewed since the previous inspection was medication management.

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 director of care is now dedicated to overseeing the quality of the service provided and is not covering staff nurse duties. We are undertaking a gap analysis which will cover every aspect of our service with the help of health care consultants and ensure that the service we provide will comply with all HIQA standards.

Proposed Timescale: 31/01/2017

Theme:

Governance, Leadership and Management

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

The duty roster evidenced that senior clinical staff including the person in charge worked in excess of standard full-time working hours on a consistent basis.

3. Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of

purpose.

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

We now have a full complement of nurses. Two staff nurses started on 08 August 2016, one joined on 12 September 2016 and one joined on 06 October 2016. All of these nurses have now completed an induction programme and are Garda vetted. The person in charge is now working a standard 39hr week purely in a management role and we have appointed an assistant director of nursing on 24 October 2016 who is currently on induction.

Proposed Timescale: 26/10/2016

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:

A review of training records indicated that not all staff had up-to-date training in challenging behaviour.

4. Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

We have completed one session of training in responding to behaviours that challenge and remaining staff will be accommodated by two further training days on 11 and 25 November 2016. Training has been arranged with Barrow Training.

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

There was no standardised assessment tool to assess behaviours. Clear strategies were not outlined to support a consistent approach to the management of behaviours that challenge or that focussed on a proactive and positive approach.

5. 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:

There is now a standardized challenging behaviour assessment tool (ABC Chart) which has been added to our Epiccare nursing records system. Training for nurses on use of this tool will be addressed with the training on behaviours that challenge (Scheduled for November 2016), Director of Nursing and Assistant director of nursing will provide support to care staff in this area and carry out audits to ensure consistent documentation in the resident's care plan.

Proposed Timescale: 30/12/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The risk management policy did not include the arrangements for the identification, recording, investigation and learning from serious incidents.

6. Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

Our risk management policy will be updated to include identification, recording, investigation and learning from serious incidents. This will be addressed through the gap analysis which includes a review and update of all policies and procedures.

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

There was no emergency plan in place which would identify what to do in the event of emergencies including major incidents, loss of power and flooding. The inspector was informed that there was a plan but it was not made available to the inspector on the day of inspection nor was it furnished following inspection as requested by the inspector.

7. Action Required:

Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to

essential services or damage to property.

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

We have already forwarded our emergency plan but this will be reviewed further as part of the gap analysis that we are undertaking.

Proposed Timescale: 26/10/2016

Theme:

Safe care and support

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

Records did not evidence simulated fire drills were undertaken to reflect a night time situation when staffing levels are reduced.

8. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Night time fire drills will be carried out starting in November, all staff will have participated in at least one fire drill before the end of November 2016.

Proposed Timescale: 30/11/2016

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:

The inspector reviewed a number of the prescription and administration sheets and identified issues that did not conform with appropriate medication management practice:

- Red ink was used in charts viewed by the inspector which is not in accordance with best practice in medication management
- there were gaps identified in a sample of the medication administration records reviewed, therefore it was impossible to ascertain if the medicines had been given to the resident or not

•it was observed that not all medications were individually prescribed by the prescriber which is not in accordance with best practice.

9. 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:

Use of red ink is discontinued. G.P's have been advised that prescriptions need to be individually signed. An audit on the medication records to identify gaps in signing for medications issued will be carried out by the director of nursing in November.

Proposed Timescale: 30/11/2016

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:

The inspector was told that residents or their next of kin were involved in the care planning review process. However, this was not consistently documented in residents' care plans.

10. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

The care plans for each resident will be produced on a hard copy for consultation with the resident and where appropriate members of the resident's family. Residents and families will be asked to sign the care plan following consultation.

Proposed Timescale: 31/01/2017

Theme:

Effective care and support

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

Residents' had a comprehensive assessment completed on admission. However, each need identified on assessment did not always have a corresponding care plan in place

to reflect this need.

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:

New nursing staff will undertake training and in service around care plans and the director of nursing and assistant director of nursing will work together to ensure that all identified needs will have a corresponding care plan in place.

Proposed Timescale: 31/01/2017

Theme:

Effective care and support

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

There was inconsistent evidence of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell.

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:

All deficits in care planning will be addressed by our review of care plans in consultation with HCI. We are currently using the 'Think Ahead' format to discuss advance planning issues with family. All resident files will be audited to ensure that documentation is consistent.

Proposed Timescale: 31/01/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

There were no dates on the matrix for mandatory and other training therefore the inspector could not ascertain when the training had been completed.

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:

The training matrix has been updated and dates included to show completed training.

Proposed Timescale: 26/10/2016

Theme:

Workforce

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

The inspector was not satisfied with the supervision systems in place. The person in charge was frequently replacing nursing staff in direct care provision and staff appraisals were not completed on an annual basis.

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:

The person in charge is no longer replacing nursing staff. An assistant director of nursing has also joined the team and staff appraisals will be completed by schedule.

Proposed Timescale: 31/12/2016