Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Powdermill Nursing Home & Care Centre
Centre ID:	OSV-0004456
Centre address:	Gunpowdermills, Ballincollig, Cork.
Telephone number:	021 487 1184
Email address:	powdermillnursing.home@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	JCP Powdermill Care Centre Limited
Provider Nominee:	Joseph Peters
Lead inspector:	John Greaney
Support inspector(s):	Mary O'Mahony
Type of inspection	Unannounced
Number of residents on the date of inspection:	39
Number of vacancies on the date of inspection:	1

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 June 2016 10:00	22 June 2016 19:00
23 June 2016 08:20	23 June 2016 21:30

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 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Major
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

Powdermill Nursing Home and Care Centre is located close to the town of Ballincollig, which is approximately nine kilometres west of Cork city. It is a three storey premises, however, all resident accommodation is on the ground and first floors.

This inspection was a monitoring inspection, it was unannounced, took place over two days and was the 15th inspection undertaken by HIQA of Powdermill Nursing Home and Care Centre. As part of the inspection, inspectors met with residents, the provider, person in charge, the operations manager, and staff members. Inspectors observed practices and reviewed documentation such as residents records, incident records, staff training records, staff files and the complaints log. Overall, inspectors were not satisfied that there was an adequate level of 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. Four immediate action plans were issued on the second day of the inspection in relation to inadequate safeguarding practices, inadequate supervision of staff, the inappropriate use of restraint and the risk management of smoking. The provider submitted a response to the immediate action plans on the day following the inspection and these are contained at the end of this report.

On this inspection a number of improvements were noted in the premises, such as the replacement of a platform lift with a new lift; the leveling of the floor leading to the nursing station; the replacement of damaged floor covering; internal and external painting; and the renovation of a number of bedrooms and en suites. However, a condition of registration was that all improvements were to be carried out on the premises by September 2015 but these works were not completed in full. The provider was informed that he was in breach of the conditions of registration and should have submitted an application to vary the conditions as soon as he became aware that this condition could not be met.

There was evidence of good practice in relation to residents' rights and daily routine. Residents could go to bed at a time of their choosing and were supported to get up and have breakfast at a time of their choosing. The was a good programme of activities and residents were seen to participate in activities enthusiastically.

Significant improvements were required in relation to safeguarding practices and the supervision of staff where performance issues were identified. Inspectors were not satisfied that adequate safeguarding arrangements were put in place to safeguard residents when there were suspicions or allegations of abuse. Additionally, where staff performance was not at the desired standard, adequate supervision arrangements were not put in place to ensure that performance had improved to an acceptable level. Also, HIQA was not notified, as required, of allegations of abuse or of allegations of staff misconduct.

Improvements were required in relation to fire safety, and in particular the risk management of smoking. The risks associated with the unauthorised smoking by a resident in their bedroom was not adequately addressed and significant risks were identified on the first day of inspection. Adequate control measures had not been put in place to address the risks identified. Improvements were also required in relation to fire drills, in particular the inadequate fire drills to support the evacuation of residents located on the first floor.

Additional improvements required, included:
• inadequate understanding of regulatory requirements by the provider and person in charge
• provision of inaccurate information to inspectors in relation to the use of restraint
• inappropriate use of restraint
• infection prevention and control, particularly in relation to storage of clinical equipment
• medication management

The action plan at the end of this report sets out the actions necessary 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
There were adequate resources available to support the effective delivery of care. There was a clearly defined management structure. The person in charge reported to the provider and was supported in her role by a clinical nurse manager that worked part time. There were regular clinical governance meetings that were attended by the provider, person in charge and clinical nurse manager.

There was an annual review of the quality and safety of care. There were a number of audits carried out throughout the year, such as medication management audits, care plan audits, staff training audits, audit of complaints, relative/resident surveys and food satisfaction surveys. There was an associated action plan identifying who was responsible for addressing the issues identified for improvement through the audit process. Improvements, however, were required in relation to management systems to ensure that the service provided was safe. There was a lack of understanding of the regulatory requirements by the provider and person in charge in relation to the management of the centre including protection of residents, supervision of residents and staff, and submission of notifications to HIQA. Additionally, a condition of registration was that certain improvements were to be carried out on the premises by September 2015. However, these works were not completed in full and the provider had not submitted a request to vary the conditions of registration.

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:
There was a person in charge who was a registered nurse, worked full time and had adequate experience in the area of nursing of the older person. There was evidence that the person in charge was involved in the day to day running of the organisation and residents could identify the person in charge.

Improvements were required in relation to the person in charge's knowledge of the legislation and statutory responsibilities. For example, as will be discussed in more detail under Outcome 10, notifications required to be submitted to HIQA in relation to allegations of abuse and staff misconduct were not submitted. Additionally, inspectors were not always provided with accurate information in relation to the use of restraint. These actions are addressed under Outcome 2.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
In general, records were kept secure and easily retrievable, however, the complaints log available in the centre on the days of inspection only held complaints made since 18th April 2016 and the old complaints log had been archived.

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

Findings:
Overall, significant improvements were required in relation to safeguarding practices. There was a policy in place in relation to safeguarding residents from abuse. Training records indicated that all staff had up-to-date training on recognising and responding to abuse. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse. However, based on a review of records, inspectors were not satisfied that the training was effective. This was particularly relevant in relation to the behaviour of a small number of staff that did not appear to understand that certain behaviours could be potentially upsetting to residents. For example, records indicated that staff may have on occasion expressed displeasure at the performance of certain duties or used bad language while in the company of residents.

Where allegations of abuse were made against staff members, records indicated that these were investigated. Inspectors, however, were not satisfied that adequate measures were put in place to safeguard residents while the investigation process was underway or following the investigations, where the allegations were upheld. For example, following the issuing of a verbal warning to staff members, a safeguarding plan or process of supervision was not put in place to safeguard residents. An immediate action plan was issued to the provider on the day of inspection to put adequate procedures in place to safeguard residents. Residents spoken with by inspectors stated that they felt safe.

There were systems in place to safeguard residents' finances. Based on a sample of records viewed by inspectors, adequate records were maintained on transactions made by or on behalf of residents. However, the system could be enhanced through more regular audits, as the balance on record for one resident did not correlate with the money held in the account. The discrepancy, however, was in favour of the resident.

There was a policy in place on the management of responsive behaviour. Staff spoken with by inspectors were knowledgeable of the triggers that may precipitate responsive behaviour and the measures to be taken to support residents. There was a policy in place on the management of restraint. On the first day of the inspection, inspectors

noted that one resident had a restrictive lap restraint in place. Inspectors were informed that this restraint was in place to support the correct positioning of a resident while in the chair and had only been put in place on the morning of inspection. Discussions with staff and records reviewed, however, indicated that this restraint had first been put in place three days prior to this inspection. There was no record, however, to demonstrate that alternatives to the use of restraint were adequately explored prior to the use of the restraint. There was no risk assessment completed prior to the use of restraint. On the second day of inspection, inspectors noted an assessment for the use of this restraint. however, the time recorded on the assessment did not correlate with the time that it was completed. Records were not available of safety checks or to demonstrate that the restraint was released periodically throughout the day. There was no assessment of the resident by a suitably qualified professional to demonstrate that this type of restraint was required or appropriate. An immediate action plan was issued to the provider to ensure that when restraint was used that it was done in accordance with national policy.

Judgment:
Non Compliant - Major

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

Theme:
Safe care and support

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

Findings:
There was an up-to-date risk management policy and associated risk register that addressed the items listed in the regulations. The risk register, however, required to review to ensure that it accurately reflected the current risks in the centre, as many of the risks identified were dated 2014 and there was no evidence of on-going review. There was a plan in place for responding to emergencies.

There was a policy in place for infection prevention and control. Wash hand basins were available at suitable locations and hand hygiene dispensers were available throughout the centre. Staff members were seen to avail of hand hygiene opportunities. Improvements, however, were required in relation to infection prevention and control practices. For example, a nasal prongs used to administer oxygen to residents and a mask used for the administration of nebulisers were stored incorrectly and were seen to be on the ground, which was poor infection prevention and control practice. Additionally, some nebulisers that were not in use, contained what appeared to be the remains of liquid medication, which could pose a risk of infection to residents. Records were not available to demonstrate when these masks were first used and when they should be replaced. A protective lid was missing from one incontinence disposal unit, however, this was immediately replaced when pointed out to staff.

Records were available to demonstrate that fire safety equipment, fire alarm system and emergency lighting were serviced regularly. A number of improvements, however, were required in relation to fire safety. For example, a number of staff, including senior nursing staff, did not have up-to-date fire safety training. Some staff spoken with by inspectors did not demonstrate adequate knowledge of the alarm system, particularly how to identify the location of a fire.

Ten residents were accommodated in bedrooms upstairs that was accessible by both lift and stairs. There were emergency evacuation chairs and ski pads available close to these rooms and there were ski sheets under each mattress, to support evacuation in the event of an emergency. There was also an emergency stairs that led to the rear of the premises for use in the event of an emergency evacuation. While there were personal emergency evacuation plans in place for all residents, these did not contain adequate detail of the most appropriate means of evacuating each resident. Records were available of periodic fire drills, however, there was insufficient detail to demonstrate what was done during the fire drill and any learning from the drill. Inspectors were informed that no fire drills had been carried out to practice the evacuation of residents from the upstairs bedrooms. Fire drills were not carried out at sufficient intervals, given the design and layout of the premises. Door wedges were noted to be used to hold a number of bedroom doors, which is not in compliance with good fire safety practice. Additionally, the door to one bedroom had a damaged smoke seal. The procedures in place for monitoring fire safety practices did not identify these deficits.

There was a smoking room located beside the dining room and leading out onto some decking. The smoking room was ventilated to the exterior by natural and mechanical means. There was a fire blanket and fire extinguisher located in the room. A sign on the door indicated that the smoking room was being decommissioned on the day of inspection and a new smoking shelter had been built outside. This was being done to facilitate access to the decking by residents that did not smoke as it could only be accessed by going through the smoking room. Inspectors were not satisfied that the new smoking shelter was completed to the required standard to safely accommodate residents that smoked. For example, there was exposed timberwork and roof slabs. Additionally, there was no ashtray available and there was no fire safety equipment provided. Inspectors advised the provider and person in charge that the new smoking shelter was not fit for use.

A number of residents smoked. The risk assessment for smoking completed for all residents was not adequate, as it did not identify adequate control measures for the risks identified. For example, the risk assessment did not adequately take into consideration issues such as the risk of residents smoking in their bedrooms, the risk associated with the storage of flammable materials in bedrooms of residents that smoked, or the use and inappropriate storage of oxygen in bedrooms. Where additional control measures that were put in place, such as an additional smoke detector, it was not adequate.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
There were written policies and procedures in place in relation to medication management. Medications were stored appropriately and there was a system in place for returning unused/out-of-date medicines to the pharmacy. Medications requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded. Medications requiring special control measures were counted at the end of each shift by two nurses.

A sample of prescription and administration records were reviewed. Some prescriptions were handwritten and others were printed. The handwritten prescriptions were not always clearly legible and many had a significant number of medications that were discontinued making it difficult to read what was currently prescribed. Pre-printed medication administration records (MAR) were supplied by the pharmacy containing the information detailed on the prescription, such as drug name, dosage, route of administration and frequency of administration. Some improvements, however, were required. For example, from a small sample of prescriptions reviewed, the dosage of medication differed on the MAR sheet from what was written on the prescription. The medication supplied, however, matched that written on the prescription. Where a MAR sheet had not been supplied for a particular medicine, nurses wrote in the medicine on another MAR sheet and signed it as being administered. A review of the MAR sheets indicated that a medicine that was prescribed daily was mistakenly omitted on a number of days. Additionally, a prn (as required) medicine was written in the MAR sheet as being administered on two occasions and neither one was dated. It was therefore not possible to determine when these medicines were administered.

Judgment:
Non Compliant - Major

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

Theme:
Safe care and support

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

Findings:
Quarterly notifications were submitted as required. However, based on a sample of records reviewed by inspectors, not all notifications required to be submitted within three days were submitted as required. For example, notifications of allegations/suspicions of abuse were not always submitted, notifications of staff misconduct were not always submitted and an incident where a resident left the centre without leave was not submitted as required.

Judgment:
Non Compliant - Major

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

Theme:
Effective care and support

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

Findings:
Inspectors reviewed a sample of residents' assessments and care plans. Pre-admission assessments were completed on all residents. Residents were comprehensively assessed on admission using recognised assessment tools for issues such as the risk of falling, the risk of malnutrition, the risk of developing pressure sores and mobility status. Based on the sample of care plans reviewed, care plans were person-centred and provided adequate guidance on the care to be delivered. However, updated guidance from allied health services was not always incorporated into care plans in a timely manner. For example, the care plan for a resident that had been discharged from hospital did not include the most recent advice from a physiotherapist in relation to assisting the resident to mobilise.

Residents had access to the services of a general practitioner (GP) and records indicated residents were reviewed regularly. Out-of-hours GP services were also available. Residents had access to allied health/specialist services such as physiotherapy, speech and language therapy (SALT), chiropody, dietetics, and palliative care services.

Judgment:
Substantially Compliant

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

Findings:
Powdermill Nursing Home is located close to the town of Ballincollig. It is a three storey premises, however, all resident accommodation is on the ground and first floors. The upper floor can be accessed by stairs and lift. Bedroom accommodation on the ground floor comprises 18 single bedrooms, one twin bedroom and three triple bedrooms. Bedroom accommodation on the first floor comprises four single bedrooms and two triple bedrooms. One of the single bedrooms on the first floor had previously been a twin bedroom but was reduced to a single due to the inadequate size and layout of the room. For operational purposes the centre is divided into three sections; Millrace which includes bedrooms one to nine; Cooperage, which includes bedroom ten to 15; and Barges, which includes bedrooms 18 to 28.

All of the bedrooms on the ground floor are en suite with toilet and shower. On the first floor one triple bedroom is en suite with toilet and shower and the other triple bedroom is en suite with toilet only. There are two communal bathrooms on the first floor, one with a toilet and shower and the other with a toilet only. Two of the single bedrooms on the first floor are above floor level and are accessed by a ramp and the remaining two single bedrooms are below floor level and are accessed by three steps.

A condition of the registration of this centre was that a programme of works would be completed by September 2015 to renovate the premises. On this inspection a number of improvements were completed, such as the replacement of a platform lift with a new lift; the levelling of the floor leading to the nursing station, which involved lowering the roof of a cellar; the replacement of damaged floor covering; internal and external painting; the renovation of a number of bedrooms and en suites; the replacement of the shower tray in the bathroom on the first floor; the laundry was extended to provide more space to segregate clean and dirty linen; and the acquisition of new bedroom furniture for a number of bedrooms. However, some works remained outstanding, such as the renovation and reconfiguration of rooms 21 and 22, both of which are triple bedrooms, and the replacement of the floor covering on Millrace corridor. The provider was informed that he was operating outside the conditions of registration and was required to submit an application to vary the conditions of registration.

Additional improvements identified on this inspection included repair of the ceiling in the

dining room which was damaged due to an old leak in the roof.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
There was a policy and procedure on the management of complaints. There was a notice on display outlining the complaints process. Both the complaints policy and notice on display required review as the appeals process was not clearly outlined in either. Additionally, the policy did not outline who was responsible for ensuring that all complaints are appropriately responded to.

Inspectors reviewed the complaints log that was available in the centre. The complaints log only contained a small number of recent complaints and the old complaints log was archived and not available in the centre on the second day of inspection. A review of the complaints log indicated that, for most complaints, details of each complaint was recorded, the investigation process, the outcome of the complaint and whether or not the complainant was satisfied with the outcome of the complaints process. The record for one complaint, however, did not detail what, if any, investigation had taken place.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
Residents were consulted about how the centre was planned and run through residents' meetings. Discussions with residents indicated that issues raised were addressed. Residents had access to the services of an independent advocate, however, advocacy services had not been contacted for one resident that may have benefitted from the service. This was addressed on the second day of the inspection.

Routines and practices supported residents' independence. Residents were supported to go to bed and get up in the morning at a time of their choosing. Residents that chose to have breakfast in their rooms were facilitated to do so and some residents were seen to have their breakfast in the dining room at various times throughout the morning. Some residents were seen to make cups of tea/coffee for themselves whenever they wished.

There was a comprehensive programme of activities that was facilitated by two activity coordinators working on opposite shifts and providing the service from Monday to Saturday. Discussions with residents indicated that they were very pleased with the available activities and inspectors observed residents participating enthusiastically in activities on the days of inspection. Activities included chair based exercises, bingo, music sessions, and arts and crafts. Inspectors also observed one-to-one activities being provided to residents that did not wish to participate in group activities. Some residents informed inspectors that they had watched the football match on television the previous night and were provided with alcoholic and non-alcoholic beverages and snacks. Mealtimes were seen to be social occasions and residents were seen to interact with each other while dining.

There was no restrictions on visitors and visitors were seen to come and go throughout the day. Visitors appeared to be familiar with staff and were welcomed by staff. Residents had access to radio, television and newspapers. Religious and cultural practices were facilitated and residents were facilitated to vote in local and national elections.

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:
A review of the staff roster indicated that the person in charge worked from Monday to Friday and was supported by a clinical nurse manager who worked approximately two shifts each week, also Monday to Friday. Both the person in charge and clinical nurse manager were supernumerary. There were two registered nurses on duty each day from 07:30hrs to 19:30hrs. There were six healthcare assistants on duty each morning until 14:00hrs, five until 16:00hrs, four until 18:00hrs and three until 22:30hrs. There was one nurse and two healthcare assistants on duty each night. Housekeeping staff had been increased since the last inspection and there were now three staff on each day until 13:15hrs and one in the afternoon until 18:00hrs. Additional staff included a chef, an activities coordinator, a laundry assistant, an operational manager and two administration staff. Feedback from staff and residents indicated that there were insufficient staff on duty, particularly in the morning time. Nursing staff spoken with by inspectors confirmed that they were available to assist with personal care until 08:30hrs each day but were then involved in medication administration until approximately 11:00hrs. The provider was requested to review staff levels/work practices to ensure that sufficient staff were at all times available to meet the needs of residents.

Based on a sample of records reviewed and discussions with management, a small number of staff had undergone a disciplinary process. The disciplinary process was as a result of complaints either by residents, relatives or other staff members. Where the outcome of the disciplinary process indicated that staff performance was not at acceptable level, verbal warnings had been given. However, no additional supervision arrangements were put in place to ensure that the performance of these staff had improved to an acceptable level and no performance development plan was in place to address any deficiencies identified.

A review of a sample of staff files indicated that most of the requirements of the regulations were met. However, the employment history for one staff member did not contain a satisfactory explanation for gaps in employment and some staff references did not did not have any evidence that they were verified.

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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	Powdermill Nursing Home & Care Centre
Centre ID:	OSV-0004456
Date of inspection:	22/06/2016
Date of response:	15/07/2016

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:
A condition of registration was that certain improvements were to be carried out on the premises by September 2015, however, these works were not completed in full and the provider had not submitted a request to vary the conditions of registration.

1. Action Required:
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for

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

Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

Please state the actions you have taken or are planning to take:
An application to vary conditions has been lodged and the application has been deemed to be complete and has been forwarded to the inspectorate. The delay in completing the outstanding items was due to delays in receiving a disability access certificate. A detailed plan is now in place to complete the works.

Proposed Timescale: 30/09/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a lack of understanding of the regulatory requirements by the provider and person in charge in relation to the management of the centre including protection of residents, supervision of residents and staff, submission of notifications to HIQA

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 Provider and Person in Charge have reviewed the issues raised and studied the guidelines for notification and accept that some notifications were not made in a timely manner or were not categorised correctly. We are satisfied that all incidents whether of abuse or otherwise were recorded and investigated and were available to inspectors on the day of inspection.
Daily Management : The Person in Charge when on duty will deal with any suspected incident of abuse or suspected misconduct of staff that occurs and will now report same to the Regulator within the time frame. She will review any incidents from the previous night shift also.
When not on duty the nurse in charge will report any suspected elder abuse immediately to the Person In Charge and the Provider to ensure that the nurse has taken all measures to safeguard all our residents. The nurse in charge is further authorised to suspend any staff member from duty immediately pending a complete investigation and also to summon extra staff where required.
The Provider and Person In Charge will continue to review all incidents weekly at clinical governance and ensure that the notifications have been completed within the required timeframe.

Proposed Timescale: 15/07/2016

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:** While there was a policy in place in relation to safeguarding residents from abuse, it required review, as it did not make reference to the HSE policy on safeguarding, as required. **3. Action Required:** Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice. **Please state the actions you have taken or are planning to take:** Our policy is being reviewed to include the HSE policy on safeguarding residents.
Proposed Timescale: 22/07/2016
Theme: Governance, Leadership and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** In general records were kept secure and easily retrievable, however, the complaints log available in the centre on the days of inspection only held complaints made since 18th April 2016 and the old complaints log had been archived. **4. Action Required:** Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. **Please state the actions you have taken or are planning to take:** The Centre has a bound complaints register for each year. The inspectors were shown the register for 2016 and the first complaint was clearly recorded on the 26th January 2016. The complaints register for 2015, whilst having been archived could have been retrieved easily if requested. The old complaints register have been taken out of archive and are now accessible when required.
Proposed Timescale: 15/07/2016
Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A review of a sample of staff files indicated that most of the requirements of the regulations were met. However, the employment history for one staff member did not contain a satisfactory explanation for gaps in employment and some staff references did not did not have any evidence that they were verified.

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

Please state the actions you have taken or are planning to take:
An audit of all staff files will be completed to ensure that all references are verified and that there are no gaps in their c.v.
All new staff are interviewed and references are checked by the interviewer and verified

Proposed Timescale: 29/07/2016

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:
Inappropriate restraint was used without adequate assessment and care plan.

6. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
The Person In Charge has reviewed our current policy and procedures in relation to restraint. Our policy on restraint has been reviewed and amended to comply with the National Policy On The Use of Restraint.
Existing documentation in relation to restraint has been changed to make it more user friendly and compliant with National Policy.
The restraint register has been updated also and any restraint used can only be used after a thorough nursing assessment. This restraint register is checked daily and signed by the person in charge and the designated nurse in charge at weekend or when the Person In Charge is off duty.
All nursing staff have been made aware of the National Guidelines on restraint and trained in the use of restraint and completion of assessment and have access to a new folder which contains all current guidelines on restraint.

We are committed to providing a restraint free environment in so far as this is possible.

Proposed Timescale: 15/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on a review of records, inspectors were not satisfied that training on recognising and responding to abuse given to staff was effective. This was particularly relevant in relation to the behaviour of a small number of staff that did not appear to understand that certain behaviours could be potentially upsetting to residents.

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

Please state the actions you have taken or are planning to take:
The staff members identified have been interviewed and a frank discussion has taken place. A performance improvement plan has been put in place and is monitored daily by the staff nurse and is reviewed weekly by our CNM. The extent and duration of the improvement plan will be determined by the CNM in consultation with the Person in Charge and Registered Provider

Proposed Timescale: 15/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Where allegations of abuse were made against staff members, records indicated that these were investigated. Inspectors, however, were not satisfied that adequate measures were put in place to safeguard residents while the investigation process was underway or following the investigations, when the allegations were upheld.

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

Please state the actions you have taken or are planning to take:
Where allegations of abuse are made the Person In Charge is informed immediately during the day shift and at the end of the shift for night duty. The staff member who is suspected of abuse can be suspended immediately pending an investigation. All staff who were involved will be interviewed promptly and the security cameras will be reviewed as soon as possible but not later that 48 hours after the incident.

The staff nurses have been given a detailed memo on how to deal with a suspected case of abuse and how to safeguard the residents in the aftermath of any incident. Where an allegation is upheld, the Person in Charge with the Registered Provider shall determine if the staff member can be allowed to return to work. If they are allowed to return to work a performance improvement plan that includes daily supervision will be put in place. Where further training is deemed necessary this will be facilitated by the supervisor which will include learning outcomes.

Proposed Timescale: 15/07/2016

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 register required review to ensure that it accurately reflected the current risks in the centre, as many of the risks identified were dated 2014.

9. 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:
The risk register has been fully reviewed and risks that were identified in the past have been re-assessed and new control measures put in place. All current hazards have been identified and risk reduction measures recorded.

Proposed Timescale: 15/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to infection prevention and control practices such as a nasal prongs used to administer oxygen to residents and a mask used for the administration of nebulisers were stored incorrectly and were seen to be on the ground, which was poor infection prevention and control practice. Additionally, some nebulisers that were not in use, contained what appeared to be the remains of liquid medication, which could pose a risk of infection to residents. Records were not available to demonstrate when these masks were first used and when they should be replaced.

10. 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:
Our procedures were reviewed and the following has been implemented.
A record has been put in place to record when masks are changed. These masks are replaced as necessary but not less than weekly. Each mask will be identified by a date sticker on commencement of use.
All nursing staff have been given clear instruction on the use and storage of masks.
The person in charge/clinical nurse manager will do unannounced checks regularly and a monthly audit to measure compliance.

Proposed Timescale: 15/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records were available of periodic fire drills, however, there was insufficient detail to demonstrate what was done during the fire drill and any learning from the drill. Inspectors were informed that no fire drills had been carried out to practice the evacuation of residents from the upstairs bedrooms. Fire drills were not carried out at sufficient intervals, given the design and layout of the premises.

11. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
In consultation with our Fire Consultants Apex fire we have developed a new document to record all relevant information gathered at the fire drills which includes learning outcomes. The registered provider will ensure that fire drills are carried out as necessary but not less than once a quarter, with extra emphasis on evacuation on the first floor.
Sixteen members of staff received fire prevention training incorporating a practical demonstration of evacuation from a compartment on the 1st of July 2016
A Personal Emergency Evacuation plan has been put in place for every resident in the Centre.
Procedures to be followed in the event of a resident's clothes catching fire were included in the fire training.

Proposed Timescale: Revised Fire drill 22nd July 2016

Proposed Timescale: 22/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of staff, including senior nursing staff, did not have up-to-date fire safety training.

12. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
All senior nursing staff, staff nurses, health care assistants and the health and safety officer attended fire safety training on the 1st of July.
A further fire training session will be scheduled for September 2016

Proposed Timescale: 30th September 2016 for additional training session

Proposed Timescale: 30/09/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff spoken with by inspectors did not demonstrate adequate knowledge of the alarm system, particularly how to identify the location of a fire.

13. 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:
All staff received training on the fire panel as part of induction on the first day at work and during fire training and during fire drills. All staff will be retrained on how to read the information displayed on the fire panel which indicates the location of the fire.

Proposed Timescale: 31/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
The use of door wedges to keep doors open which is not in compliance with appropriate fire safety practice.

14. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
All wedges have been removed and this is monitored daily. Where residents have indicated that they would like the option of the door open this will be facilitated via electronic door closures.

Proposed Timescale: Removal of wedges and monitoring completed. Three rooms will have electronic closures fitted by 31st July 2016

Proposed Timescale: 31/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The door to one bedroom had a damaged smoke seal.

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

Please state the actions you have taken or are planning to take:
This was replaced on the day of inspection.

Proposed Timescale: 15/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were personal emergency evacuation plans in place for all residents, these did not contain adequate detail of the most appropriate means of evacuating each resident.

16. 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:
A Personal Evacuation Plan has now been completed for each resident and contains adequate details of the most appropriate means of evacuating each resident.

Proposed Timescale: 15/07/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk assessment for smoking completed for one resident was not adequate, as it did not identify adequate control measures for the risks identified. For example, this resident was known to periodically smoke in the bedroom. While an additional smoke detector had been placed in the resident's bedroom, records indicated that the resident continued to smoke periodically in the bedroom. The bedroom was cluttered with lots of books.

17. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
A revised risk assessment was undertaken at the time of inspection and reviewed again with the resident on the 12th July
Additional smoke detectors have been fitted on the landing outside his room and one in the toilet adjoining his room.
A third smoke detector will be fitted to the room when a suitable cigarette smoke detector is sourced.
The resident who is an avid reader and takes solace in his book collection will be encouraged to relocate some of his books..
A new fire blanket will be located outside his room.
The soft furnishings in his room have been reviewed and replaced with fire retardant equipment where necessary.

Proposed Timescale: Risk Assessment are completed
New smoke detector 31st August 2016

Proposed Timescale: 31/08/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Inspectors were not satisfied that the new smoking room was completed to the required standard to safely accommodate residents that smoked. For example, there was exposed timberwork and roof slabs. Additionally, there was no ashtray available and there was no fire safety equipment provided.

18. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

Please state the actions you have taken or are planning to take:
The opening of the smoking room was deferred and the existing smoking room continues in use. The proposed new smoking room has been fire slabbed and plastered. Additional fire extinguishers and a fire blanket will be placed in the new smoking facility. It will not be commissioned until we are satisfied that adequate precautions for the safety of residents are in place.

Proposed Timescale: 31/07/2016

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:
From a small sample of prescriptions reviewed, the dosage of medication differed on the MAR sheet from what was written on the prescription.

A review of the MAR sheet indicated that a medicine that was prescribed daily was omitted on a number of days.

A PRN (as required) medicine was written in the MAR sheet as being administered on two occasions and neither one was dated. It was therefor not possible to determine when these medicines were administered.

19. 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:
A system was put in place between the Nursing Home, the Pharmacy and the Gp's to review the central prescriptions of all residents. The central prescriptions of 30 residents have been reviewed in full and 8 central prescriptions are currently being prepared by the Pharmacy.

The Person In Charge will review the central prescriptions as part of a weekly audit and order new ones from the Pharmacy as required.

Each new central prescription has been compared with the MAR sheet so that the dosage on the central prescription and the MAR sheet are the same. As a further precautionary method and to ensure staff nurses understand their obligations to check the accuracy of all medication documents starting on the 18th July to 22nd July the Person in Charge will meet with each nurse and again audit all the central prescriptions and the MAR sheets. Thereafter a random sample will be audited each week. To ensure that the appropriate MAR sheets are always available to the nursing staff, the staff nurse will now sign for accepting a new MAR sheet when medication is delivered each day. In addition a dedicated e-mail address has been established so that an electronic copy is available at any time for the staff nurse to print.

All of the nurses were made aware of this inspection report at a nurses meeting held on the 29th June and their professional obligations were outlined to them at that meeting. Furthermore all of the nurses have been instructed to complete the HSE on line management course and produce their certificates by the 31st of July.

Proposed Timescale: 30 central prescriptions completed.
Remaining 8 central prescriptions : 22nd July 2016
Further audit of all central prescriptions and mar sheets : 29th July
Weekly Audit : Starting weekly from 18th July

Proposed Timescale: 29/07/2016

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Failure to submit all notifications required to be submitted within three days. For example, notifications of allegations/suspicions of abuse were not always submitted, notifications of staff misconduct were not always submitted and an incident where a resident left the centre without leave was not submitted as required.

20. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
The Person In Charge and the Registered Provider have reviewed the notifications and accept that the reporting of incidents were not always reported as required. Procedures are now in place to ensure that notifications are completed. Part of this procedure is the Person In Charge and Provider being informed of any suspected

abuse, or resident absconsion as soon as the incident happens. This ensures the immediate safety of residents and timely reporting.

Proposed Timescale: 15/07/2016

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:
Based on the sample of care plans reviewed, care plans were person-centred and provided adequate guidance on the care to be delivered. However, updated guidance from allied health services was not always incorporated into care plans in a timely manner. For example, the care plan for a resident that had been discharged from hospital did not include the most recent advice from a physiotherapist in relation to assisting the resident to mobilise.

21. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
All care plans are assigned to named nurses who are responsible in the first instance to formally review care plans and update where necessary.
Where residents are returned from hospital, or has a significant change in their health and wellbeing the Person In Charge will audit the care plan of that resident in consultation with the named nurse preferably or the staff nurse on duty to ensure that it is reflective of the residents current needs.
A monthly list of all care plans due for formal review will be maintained in the nurses station which can be easily accessed by the nursing team and nursing team leaders as a reminder for each key nurse. The Person in Charge will conduct monthly audit to validate that each care plan has been reviewed timely and adequately.

Proposed Timescale: 15/07/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider failed to operate according to the conditions of registration outlined in the centre's statement of purpose.

22. Action Required:
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
The Provider will apply in future in a timely manner when dates for completion of projects encounter unforeseen delays, for a variation of conditions of registration.

Proposed Timescale: Application to vary conditions submitted

Proposed Timescale:

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Required improvements identified on this inspection included repair of the ceiling in the dining room, which was damaged due to an old leak in the roof.

23. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
The damaged ceiling will be replaced and repainted.

Proposed Timescale: 31/08/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a policy and procedure on the management of complaints. There was a notice on display outlining the complaints process. Both the complaints policy and notice on display required review as the appeals process was not clearly outlined in either.

24. 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 complaints policy has been updated to address the appeals issue.

An independent appeals person other than the Ombudsman has been included in the appeals process and is now displayed prominently in the Centre.

Proposed Timescale: 15/07/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not outline who was responsible for ensuring that all complaints are appropriately responded to.

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

Please state the actions you have taken or are planning to take:
A person has been nominated as required by regulation and our policy has been altered to reflect same.

Proposed Timescale: 15/07/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The record for one complaint, however, did not detail what, if any, investigation had taken place.

26. Action Required:
Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.

Please state the actions you have taken or are planning to take:
This incident was investigated at the time and as the incident related to a staff member's work performance. The investigation was recorded on the staff members personnel file.

Proposed Timescale: 15/07/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Feedback from staff and residents indicated that there were insufficient staff on duty, particularly in the morning time.

27. 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 Person In Charge assesses the staffing levels daily. It is agreed that morning times can be busier and the staff to resident ratio already in place exceeds the guidelines.
An additional health care assistant has been assigned at weekend mornings from 7.30 to 13.30pm
We are recruiting a suitably qualified person to manage the dining room from 8.30 am to 11.00 am as many health care assistants spend quite a considerable amount of time in the morning in the dining room.
The Person In Charge and the Clinical Nurse Manager are available Monday to Friday to assess daily when needs of the residents change and can be "hands on" when an immediate need arises.

Proposed Timescale: Health care assistant at weekends : completed
Recruitment of additional staff member for weekly mornings. 31st Aug 2016

Proposed Timescale: 31/08/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Where there were concerns raised in relation to the performance of staff, an adequate plan for the supervision of staff was not in place.

28. 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:
All health care assistants are supervised by the two nurses each day. Where concerns are raised daily supervision of the persons involved is assigned to a specific nurse and reviewed weekly by the Clinical Nurse Manager.
Any new concerns will now be dealt with in a similar manner going forward.

Proposed Timescale: Immediate and Ongoing.

Proposed Timescale: 15/07/2016