

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Fearna Manor Nursing Home
Centre ID:	OSV-0000339
Centre address:	Tarmon Road, Castlerea, Roscommon.
Telephone number:	094 962 0725
Email address:	fearnamanor@outlook.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Eldabane Properties Limited
Provider Nominee:	Martin O'Dowd
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	45
Number of vacancies on the date of inspection:	8

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 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 specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 29 March 2017 08:55 To: 29 March 2017 18:45

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

Outcome	Provider's self assessment	Our Judgment
Outcome 08: Medication Management		Substantially Compliant
Outcome 01: Health and Social Care Needs		Substantially Compliant
Outcome 02: Safeguarding and Safety		Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation		Compliant
Outcome 04: Complaints procedures		Compliant
Outcome 05: Suitable Staffing		Compliant
Outcome 06: Safe and Suitable Premises		Compliant
Outcome 07: Health and Safety and Risk Management		Substantially Compliant
Outcome 08: Governance and Management		Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced thematic inspection. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre.

Prior to this inspection the provider had submitted a completed self- assessment document to the Health Information and Quality Authority (HIQA) along with relevant policies. The inspector reviewed these documents prior to the inspection.

The inspector met with residents, staff members and the person in charge. The inspector tracked the journey of residents with dementia and observed care practices and interactions between staff and residents. A formal recording tool was used for

this purpose. Documentation to include care plans, medical records and staff files were examined.

At the time of inspection 28 residents were identified with a dementia related condition as their primary or secondary diagnosis. Eight residents were suspected of having dementia by nursing staff. There were no residents under 65 years of age accommodated in the centre with a dementia related condition at the time of this inspection

Residents' healthcare and nursing needs were met to a good standard. Residents had timely referral to healthcare services including specialist services, health and social care professionals and psycho-geriatric services.

The centre provided a good quality service for residents living with dementia. The inspector spent a period of time observing staff interactions with residents with a dementia. The care needs of residents with dementia were met in an inclusive manner. Pre admission assessments are conducted by the person in charge.

Appropriate policies and procedures were in place to protect residents. Residents were supported to engage in activities based on their interests, capacity and life stage.

The layout and design of the centre was suitable and met the needs of the resident in a comfortable and homely way. The building was clean, spacious and decorated to a good standard throughout. All areas were bright and well lit, with lots of natural light.

A total of nine outcomes were inspected. The inspector judged three outcomes as compliant and six as substantially compliant. The Action Plan at the end of this report identifies a small number of areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National 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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 08: Medication Management
Each resident is protected by the designated centres 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:
Policies and procedures were in place to guide staff in the management of residents' medication. They included information on the prescribing, administering, recording, safekeeping and disposal of unused or out of date medicines.

The inspector reviewed a sample of drugs charts Regular medication, prn medicines (a medicine only taken as the need arises) and short-term medication were identified separately on the prescription sheets. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication. The maximum amount for prn medicine was indicated on the prescription sheets examined.

There were changes made to some of the prescribed doses on the printed kardex. The dose was altered in pen by crossing or changing the numeral in the printed format. This practice did not ensure the prescribed dose is clearly legible for the purpose of administration and requires review.

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

Judgment:
Substantially Compliant

Outcome 01: Health and Social Care Needs

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 tracked a sample of resident care plans and found that timely and comprehensive assessments were carried out and appropriate care plans were developed in line with the changing needs of residents.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores and for the risk of malnutrition and continence. A comprehensive assessment was completed on admission. Nursing staff completed clinical assessments to determine cognitive functioning levels. An occupational therapist is employed three days per week. The occupational therapist undertakes a more in-depth psycho-geriatric assessment of cognitive abilities in consultation with nursing staff to guide care intervention in relation to activities of daily living.

Care plans were developed for issues identified on assessment. Each resident had a communication care plan which outlined any problems in relation to dementia, confusion or responsive behaviours. The person in charge told the inspector work was planned to commence separating out these care plans to more clearly define the issues being managed. In future residents will have separate care plans for response behaviour from those with difficulty in relation to cognitive functioning.

There was good linkage between assessments completed and developed plans of care. Care plans described well each resident's independence and the level of assistance and support required. There was documentary evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their plan of care.

Social care assessments were completed. These were used to develop care plans or personal profiles with details of their life history, their likes and dislikes, interest and hobbies. Residents physical care needs were documented well in the daily care records.

Residents had good access to GP services. There was evidence of medical reviews to review resident's medication and more frequently when required at the request of nursing staff when a change in health status was observed. Medical records evidenced all residents were seen by a GP within a short time of being admitted to the centre.

Psychotropic medications were monitored by the prescribing clinician and regularly reviewed to ensure optimum therapeutic values. The rationale for any prescribed medication was outlined in the resident's care plan. Nursing staff in conversation outlined the need and clarified the therapeutic benefit of administration. This was reviewed by the community mental health nurse or the GP who visits the centre regularly.

The provider employs a physiotherapist who works five days. The physiotherapist is available to review all residents and undertake individual exercises to promote mobility, improve respiratory function and develop passive exercise regimes for more frail

residents. Where required each resident has a personalised exercise program developed.

The residents' nutritional needs were well met. Residents were seen to be provided with a regular choice of freshly prepared food. Menu options were available and residents on a modified diet had the same choice of meals as other residents with appropriate consideration given to the presentation of these meals.

Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. A record of residents who were on special diets such as diabetic and fortified diets or fluid thickeners was available for reference by all staff and kept under review. Systems were in place to ensure residents had access to regular snacks and drinks. All residents were appropriately assessed for nutritional needs on admission and were subsequently reviewed regularly. Records of weight checks were maintained on a monthly basis and more regularly where significant weight changes were indicated. Nutritional and fluid intake records were appropriately maintained where necessary.

There were written policies and procedures in place for end-of-life care and for the management of residents' resuscitation status. Staff provided end of life care to residents with the support of their GP and the community palliative care team. Records indicated that end-of-life preferences were discussed with residents and/or their relatives and these were documented in residents' records.

There were a number of wound care problems being managed at the time of this inspection including vascular wounds, pressure wounds and minor skin tears. One resident with a vascular wound was recently reviewed in the hospital. Professional expertise provided was followed.

All residents with wound problems being managed had care plans and wound assessment charts completed at the change of each dressing. There was regular access to a clinical nurse specialist in wound management and updating of care plans to reflect changes in specialist advice on the type and frequency of dressing regimes. Nursing notes outlined a clinical evaluation of the progress of the wound. Pain relief to be administered prior to change of dressing was outlined. However, nursing notes did not always outline a clinical evaluation of the progress of the wound and in particular the effectiveness of any pain relief administered.

A good range of pressure relieving equipment was available. The occupational therapist provided guidance in care plans to nursing staff on the management of pressure relief for individual residents and discussed various pressure relief regimes in place with the inspector. Residents with poor skin integrity were provided with air mattresses.

There was good reporting by care staff to the nursing team of any variance in a resident's skin condition observed. Care staff provided a formal report mid morning to the nursing staff after personal care was delivered to each resident. However, as described in Outcome 7 Health, Safety and Risk Management there was variance in reporting accidents or incident which resulted in skin tears. Incidents reports were not completed in each case to determine a possible cause or to mitigate against a repeat occurrence of a possible skin tear.

Judgment:

Substantially Compliant

Outcome 02: Safeguarding and Safety**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 were effective and up to date safeguarding policies and procedures in place. Risks to individuals were managed. There were sufficient numbers of suitably qualified staff on each work shift to promote residents' independence.

Staff training, supervisions and an appraisal system was in place. Staff had the knowledge, skills and experience they needed to carry out their roles. The inspector observed and saw that residents were treated well. Staff spoken with were able to explain the different types of abuse, signs to look out for and how to report any concerns.

Through observation and review of care plans it was evidenced staff were knowledgeable of residents' needs and provided support that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties.

There were care plans that set out how residents should be supported if they presented with responsive behaviour. The care plans described the ways residents may respond in certain circumstances, and what action should be taken, including how to avoid situations escalating. One care read described the resident experienced negative ideation on a daily basis and outlined support strategies. Another care plan detailed auditory and visual difficulties of a resident. Personalised deescalating techniques were outlined to guide staff in their interventions.

There were policies in place to guide staff on meeting the needs of residents with responsive behaviour and restrictive practices. Policies gave clear instruction to guide staff practice. A program of training related to the care of older people with dementia has commenced. On the day of inspection some staff were participating in training and additional program was scheduled for all other staff. This was an area identified for improvement in the action plan of the previous inspection report. The training included components on how to manage responsive behaviours. The person in charge confirmed all staff would be trained by the end of April 2017.

The actions required from the previous visit in relation to restraint management procedures were completed. When a resident requested the bedrail is raised for use as an enabler, a risk assessment is now completed to ensure the practice is safe. The restraint risk assessments were reviewed and all documentation outlined better how the raised bedrail supported the resident and ensured an enabling function. There was evidence of trialling alternatives and if unsuccessful the rationale was outlined in the care plans. The number of residents with a bedrail remains high at approximately 50%. Further work to promote a restraint free environment line with national policy guidelines is required, for example there was no evidence of trialling the use of one raised bedrail as an enabler.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place at two different times for duration of 30 minutes respectively.

There were 17 residents in the sitting room during the first observation. Care staff moved amongst residents and assisted them to participate in individual activities. A small number of residents were seated around a large dining table in the centre of the room and engaged in reading magazines and newspapers. One mobile resident was closely monitored by staff and diversion techniques were used at intervals including flower arranging. The inspector concluded at the end of the 30 minute observation period the majority of residents experienced positive connective care, scores of +2. However, for one resident the observation period identified scores of -1 (protective and controlling) care.

During the second observation period 23 residents were in the two adjoining communal sitting rooms. Residents with dementia were seen to receive care in a dignified way that respected their personhood. The inspector observed staff interactions with residents that were appropriate and respectful in manner. The physiotherapist assisted some residents

to go for a walk. Residents were served hot drinks from a trolley. Residents were asked about their preferred choice. Requests for assistance to attend the bathroom were facilitated in an attentive way. Staff understood non verbal cues and requests from residents with difficulty communicating their need and responded accordingly. There were friendly and personable interactions between residents and staff. During this observation period it was identified that for the total time of the observation period the quality of the interaction score was +2 (positive connective care) for the majority of residents and similarly to the previous observation for one resident the observation period identified scores of -1 (protective and controlling) care.

There were no restrictive visiting arrangements. Visitors were variously present throughout the day. One relative visited daily to assist with meals for their next of kin. There were areas for residents to receive visitors.

The centre had a dedicated full-time activities coordinator who managed a programme of activities and also organised special events and celebrations. There were also one-to-one activities for residents that do not participate in group activities.

Residents with dementia had access to advocacy services. There is both a collective and individual forum for residents and their next of kin to raise any concerns they have to the management team.

Residents' privacy was respected. They received personal care in their own bedroom. Bedrooms and bathrooms had privacy locks in place.

Staff delivered care in a timely and safe manner. During the inspection, residents were seen to receive attention from staff based on their care requirements, for example, responding to the call bell, and supporting people from the sitting area to the dining room or to their own bedrooms.

Judgment:

Compliant

Outcome 04: Complaints procedures

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 complaints policy in place. The complaints procedure was displayed prominently in the centre. In keeping with statutory requirements the procedure for making a complaint included the necessary contact details of a nominated complaints officer. An internal appeals process and nominated individual with oversight of the

complaints process was outlined.

A complaint file was maintained that had the facility to record each complaint with details of any investigation into the complaint and whether or not the complainant was satisfied with the outcome. No complaints were being investigated at the time of inspection.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

There was an adequate complement of staff with the proper skills and experience on each work shift to meet the assessed needs of the 45 residents accommodated at the time of this inspection. There were eight vacancies as the centre is registered to accommodate a maximum of 53 residents.

There were two nurses rostered each day of the week from 8.00am until 8.00pm. In addition the person in charge works full time five days each week. There was a regular pattern of rostered care staff. There are eight care assistants rostered from 8.00am until 2.30pm and six throughout the afternoon until 8.00pm

In addition the staffing complement includes an activity coordinator, catering, housekeeping, administration and maintenance staff. The centre did not use agency staff.

The training needs of staff were monitored. There was a varied programme of training for staff. Records viewed confirmed there was an ongoing program of mandatory training in areas such as safeguarding vulnerable adults, fire safety evacuation and safe moving and handling. Staff also had access to a range of professional development and education. Staff had completed training on end-of- life care and infection control in January 2017. Nursing staff had undertaken training in wound management in March, facilitated by a clinical nurse specialist in wound care. Refresher training in safeguarding was planned for staff in April and May to reflect changes to the policy and practice arrangements.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. Staff spoken with confirmed to the inspector they undertook an interview and were requested to submit

names of referees. Staff files contained all matters required by Schedule 2 of the regulations.

Judgment:

Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The centre is a single-storey construction. It was purpose-built and designed to meet the needs of dependent persons. It was found to be comfortable and welcoming. The centre was well maintained, warm and visually clean.

Bedrooms accommodation comprises of 15 single and 19 twin bedrooms all with en-suite bathrooms. Bedrooms are spacious and equipped to assure the comfort and privacy needs of residents. There was a call bell system in place at each resident's bed. Suitable lighting was provided and switches were within residents reach. There were a sufficient number of toilets, baths and showers provided for use by residents. Toilets were located close to day rooms for residents' convenience.

There were visual cues and pictorial signage to guide residents. Each bedroom door had a photograph of the resident on the door to help direct residents. Bedrooms were decorated with bright colours and each bedroom had a feature wall painted a different colour. Within each bedroom the resident had their name displayed in large crafted lettering alongside a life story. There were objects within some bedrooms to stimulate and help divert residents including brightly coloured paper flowers and butterflies.

There were objects of visual interest on some corridors. The design of the corridors had an open aspect allowing for continuous circular movement for residents to walk around in loop on two separate circuits. There were two murals on the corridors, one referencing local towns and another of a landscape setting. Activity boards were provided in the sitting room and at the start of the corridor from the entrance foyer. There was good use of photos to help remind residents of day trips and local outings displayed on the corridor. However, each resident did not have a clock provided in their bedroom to assist in orientation regarding time.

On the previous inspection it was identified the doors from some toilets opened out onto the corridor, restricting the view of occupants exiting bathrooms. This posed a risk to residents mobilising along the corridor. The doors have been refitted to open into the bathrooms to minimise risk of any accident along the hallways.

All parts of the building were comfortably warm, well lit and ventilated. Access to the centre and service areas are secured in the interest of safety to residents and visitors.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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:

Residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, medications reviewed and care plans were updated to include interventions to mitigate the risk of future falls.

The arrangements in place for recording and investigating incidents and near miss events require review. There was variation in practice of documenting incidents which resulted in skin tears. Some residents had dressing for skin tears or grazes. Residents with wound problems had care plans and wound assessment charts completed. However, an incident report was not completed in each case of skin tear incident. Therefore, an investigation as to the possible cause or action to minimise the risk of a repeat occurrence was not in place as a result.

The training records showed that staff had up to date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents' needs. Moving and handling risk assessments were completed for each resident. These were available for reference by care staff in residents' bedroom. They outlined the type of hoist and sling size required.

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

Access and egress to and from the building was secured in the interest of safety to residents and visitors. However, windows in en-suite bathrooms had large openable panes and were not fitted with restrictors in the interest of health and safety to prevent residents at risk of leaving the centre unaccompanied. This was identified as an area requiring action on the previous inspection.

The building, bedrooms and bathrooms were visually clean. There was a colour coded cleaning system to minimise the risk of cross contamination. A sufficient number of

cleaning staff were rostered each day of the week.

There were procedures to undertake and record internal fire safety checks. Monthly and weekly fire safety checks were undertaken. The fire extinguishers were checked to ensure they were in place and intact, the fire panel and automatic door closers were operational. Records were maintained evidencing the fire escape routes were unobstructed. There was an ongoing programme of refresher training in fire safety evacuation. This was facilitated by an external trainer.

The frequency of fire drill practices to reinforce knowledge from annual training require review to ensure staff did not have an opportunity to partake in regular drills to reinforce their knowledge from annual training. The records of fire drills require more detail to outline the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario. There was no documented evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

Judgment:

Substantially Compliant

Outcome 08: Governance and Management

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:

There was a defined management structure in place with clear lines of authority, accountability and responsibility for the provision of the service.

There were sufficient resources to ensure the delivery of care in accordance with the statement of purpose. There was evidence of investment in the professional development of staff and sufficient staff deployed to meet residents' care needs.

As identified on the previous inspection the aim, objective and methodology was not defined for quality improvement strategies. While statistical data was collated in relation to a range of clinical matters, oversight to assure the quality and safety of care requires further development.

While factors relating to fall sustained by residents were clear this was not the case for all audits. An audit on wound management included only a review of a single file. There was not an updated list of each resident with wound outlining the type wound, including

those with skin tears as discussed previously in the report and the type of dressing in place. Some audits were in a check list format and an action plan for improvement was not clear.

An annual report on the quality and safety of care was compiled by the provider. However, the format and content require review to ensure an easily understood version is available to residents and their representatives.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Fearna Manor Nursing Home
Centre ID:	OSV-0000339
Date of inspection:	29/03/2017
Date of response:	27/04/2017

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 08: Medication Management

Theme:

Safe Care and Support

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

There were changes made to some of the prescribed doses on the printed kardex. The dose was altered in pen by crossing or changing the numeral in the printed format. This practice did not ensure the prescribed dose is clearly legible for the purpose of administration and requires review.

1. Action Required:

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable

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

practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

All changes to resident Kardex will be printed and GPs signature attached. All discontinued medicines will be identified as per policy. As per current practice nurses will not administer any prescribed medications if the Kardex is deemed illegible.

Proposed Timescale: 03/04/2017

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

Nursing notes did not always outline a clinical evaluation of the progress of the wound and in particular the effectiveness of any pain relief administered.

2. 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:

Wound assessments and progress will be clearly evidenced within the wound assessment chart and resident progress notes. This will include the administration of pain relief and a review of its effectiveness and a requirement to change the level. The existing good practices will be documented.

Proposed Timescale: 10/04/2017

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Further work to promote a restraint free environment line with national policy guidelines is required. For example, there was no evidence of trialling the use of one raised bedrail as an enabler.

3. 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:

Most bed rails have been self requested by the residents themselves and usually after a period of hospitalisation where they have become used to the bed rail being in place. We always encourage alternatives and from now on this encouragement will be fully documented. To some residents the bed rails are a source of comfort and not a method of restraint.

Proposed Timescale: 10/04/2017

Theme:

Safe care and support

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

All staff had not completed training in caring for residents with dementia.

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:

As identified during the inspection this training is ongoing and staff are undergoing training and refresher courses in supporting residents with dementia and related behaviours that challenge. There is an in house trainer in this area employed by the group.

Proposed Timescale: 10/04/2017

Outcome 07: 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 arrangements in place for recording and investigating incidents and near miss events require review. There was variation in practice of documenting incidents which resulted in skin tears.

5. 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:

Current practices are being reviewed with staff and this area has recently been concentrated on. All tears and their causes will be recorded under the Incident Reporting Policy to ensure they are reviewed, analysed and the root cause identified. Any required changes to practice that are identified will be implemented immediately.

Proposed Timescale: 17/04/2017

Theme:

Safe care and support

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

Windows in en-suite bathrooms had large openable panes and were not fitted with restrictors in the interest of health and safety to prevent residents at risk of leaving the centre unaccompanied.

6. Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

The 2 windows that had no restrictors fitted had them installed on the day of the inspection

Proposed Timescale: 29/03/2017

Theme:

Safe care and support

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

The frequency of fire drill practices to reinforce knowledge from annual training require review to ensure staff did not have an opportunity to partake in regular drills to reinforce their knowledge from annual training.

The records of fire drills require more detail to outline the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario.

7. 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 undergo regular fire drills

Future fire drills will encompass the various scenarios and more detailed recording of the drill and results

Proposed Timescale: 24/04/2017

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

Statistical data collated in relation to a range of clinical matters requires oversight to assure the quality and safety of care.

8. 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:

Current audits include a sufficient number of residents to ensure the results are an accurate reflection of current practices. The implementation of actions required based on audit results will be documented in more detail and the results of the actions will be similarly recorded.

Proposed Timescale: 01/05/2017

Theme:

Governance, Leadership and Management

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

The format and content of the annual report on the quality and safety of care compiled by the provider require review to ensure an easily understood version is available to residents and their representatives.

9. Action Required:

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

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

The results of the annual review will be made available to residents and

representatives. At present they are also discussed with resident forums and at family meetings

Proposed Timescale: 03/05/2017