

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Ratoath Manor Nursing Home
Centre ID:	OSV-0000152
Centre address:	Ratoath, Meath.
Telephone number:	01 825 6101
Email address:	ratoath@silverstream.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Ratoath Nursing Home Limited
Provider Nominee:	Joseph Kenny
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	61
Number of vacancies on the date of inspection:	2

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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
16 January 2017 09:30	16 January 2017 17:30
17 January 2017 08:00	17 January 2017 18:00
18 January 2017 08:00	18 January 2017 13:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This was an announced inspection completed in response to an application made by the provider for renewal of registration. The last inspection of the centre by the Health Information and Quality Authority (HIQA) was a thematic inspection completed on 19 July 2016 to assess compliance with the regulations regarding the service provided for residents with dementia living in the centre. There were seven

action plans from this inspection, four of which were found to be satisfactorily completed. The remaining three actions were found to be partially completed and are restated in the action plan with this inspection.

The inspector spoke with residents, relatives of residents and staff members. Documentation records reviewed included the centre's policies, risk management including fire safety procedures and records, audits and staff training records. In addition pre- inspection questionnaires completed by seven resident and one relative were reviewed. The collective feedback from residents spoken with during the inspection and from pre-inspection questionnaires was satisfactory. There was evidence that the views of residents were actively sought and actions taken to address service improvements identified.

The centre premises were in a good state of repair. Recent refurbishment of the residents' communal sitting room on the ground floor in consultation with them significantly enhanced this area. Inspection findings confirmed that additional communal space was required for residents on the first floor and the lift in the centre required review. Improvement was also required to the laundry facilities. The provider had already identified these findings and had plans to address them with an extension to the premises was progressed to an advanced stage. A comprehensive review of fire safety in the centre was satisfactorily completed. The layout and space in residents' bedrooms met their needs.

Residents healthcare needs were met to a good standard. While activity coordinator hours were increased by the provider since the last inspection, activation to comprehensively meet the needs of residents with one to one and small group needs required improvement.

Procedures were in place to ensure that residents were protected from abuse. The inspector observed that all interactions by staff with residents were courteous, respectful and kind.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016).

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 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a written statement of purpose document available which was recently updated and a copy was forwarded to HIQA as required. It contained all information required by schedule 1 of the Regulations. The statement of purpose and function accurately described the range of needs that the designated centre meets and the services provided.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a clearly defined organisational and management structure in place. There was evidence of accountable and responsive management practices. This was demonstrated by service reviews, improvements made or in progress to enhance the

facilities and quality of life of residents living in the centre and safety assurances. Lines of authority and accountability were defined and all members of the team were aware of their role and responsibilities. The inspector observed that management meetings were regularly convened and were minuted. Key parameters as measures of the quality and safety of the service were consistently reviewed at this forum. Positive inter-team communication was promoted by regular meetings at each staff level.

There were systems in place to ensure that the service provided was safe, appropriate to meet resident needs, consistent and regularly monitored. Regular and consistent reviewing of key areas of clinical care, the environment and feedback from residents and their relatives was done. Action plans to address deficits identified from audits were developed and tracked to completion. An annual report detailing a review of the quality and safety of care delivered to residents in accordance with the national standards was completed for 2015 and was in draft format for 2016. This draft document was due for completion by end of January 2016. There was evidence of completion of quality improvements identified in the 2015 report for completion in 2016. Improvements progressed and those in progress were made in consultation with residents. This finding was demonstrated by meaningful actions taken in response to resident feedback on their environment and how they wanted it to be. A programme to redecorate residents' bedrooms was underway with arrangements in place to give residents choice regarding colour and design schemes for their curtains and bed covers.

Judgment:
Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
Each resident had a contract of care that described the terms and conditions of their care and welfare in the centre. The inspector reviewed a sample of residents' contracts and found them to be signed and dated. The fees and additional fees to be charged were not documented in some contracts in the sample reviewed. Residents' activation provision was included as an additional fee levied on residents accommodated in the centre under the terms of the 'Fair Deal' scheme. The inspector found that residents' agreed contract details did not reference liability by those assessed as being at increased risk of falls for the purchase of a sensor alert mat.

A resident's guide was available to each resident which advised them of the services

provided including summary details regarding the complaint process and arrangements for fire safety in the centre.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge has been in her role since January 2016. The inspector found that she had authority and accountability for the service provided and was involved in the governance, operational management and administration of the centre. The person in charge was supported in her role in managing the centre by the various departments within the larger organisation such as human resource, financial and maintenance departments.

The person in charge is a registered nurse with An Bord Altranais agus Cnáimhseachais Na hÉireann. She has a bachelor of nursing degree qualification and is scheduled to complete a postgraduate qualification in gerontological nursing. She has the required experience in caring for dependant people and management of a residential care facility gained prior to and since commencing her current role. She has a management qualification as required by the regulations. The training records confirmed that the person in charge has maintained her professional knowledge and development with attendance at various courses and training sessions. She facilitated this inspection and worked on a full time basis in the centre.

The person in charge had effective systems in place to ensure the quality and safety of clinical care. Information required was easily accessed and was well organised. Residents spoken with knew the person in charge and she had a comprehensive knowledge of residents and their needs.

Judgment:

Compliant

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:

The information as required by Schedule 1 of the regulations was documented in the centre's recently updated statement of purpose document.

Staff files reviewed contained the information as required by Schedule 2 of the regulations.

The directory of residents as required by Schedule 3 of the regulations was maintained in an accessible format. However some items of information were not consistently recorded for each resident in the centre as follows;

- parts of information required for six residents' regarding their next of kin details were not recorded in the sample reviewed
- the details of each residents' GP was not consistently recorded for a number of residents in the sample reviewed
- there was incomplete details recorded regarding temporary discharge and readmission of residents to the centre.

Other records to be maintained in respect of each resident and otherwise as described by schedules 3 and 4 of the regulations were in place and were stored securely.

All of the written operational policies as required by Schedule 5 of the Regulations were available and up to date. These policies were accessible to staff to inform their practice.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There were suitable arrangements for absences by the person in charge. A registered nurse at assistant director of nursing grade worked alongside the person in charge on a day-to-day basis. The person in charge had arrangements in place to ensure that she and the assistant director of nursing were not on leave during the same periods. This arrangement ensured that a senior member of the nursing team was available each day during the week.

Judgment:

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):

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

Findings:

There were measures in place to safeguard and protect residents from being harmed or suffering abuse. A policy was in place informing management of any suspicions, allegations or incidents of abuse to residents. There were no allegations of abuse in the centre currently being investigated. Staff spoken with were knowledgeable regarding the different types of abuse and their responsibility to report. Staff told the inspector that there were no restrictions to them reporting any incidents that they may suspect or witness. Training records confirmed that all staff had attended training in protection of residents from abuse. The inspector observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff and residents knew each other well. Residents spoken with told the inspector that they felt safe and secure in the centre.

The inspector was told that there were five residents with episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) due to dementia. Assessments had been completed and were used to inform behavioural support care plans for these residents. However, the information in some behavioural support care plans required review to ensure they clearly identified behaviours, the triggers to the behaviour and the most effective person-centred interventions to be used to de-escalate any incidents. This finding is actioned in outcome 11. Although this documentation required some review, residents' responsive behaviours were generally

well managed in practice by staff indicating that staff knew the effective de-escalation strategies for each resident. Use of PRN (a medicine only taken as the need arises) psychotropic medicines were documented in residents' behavioural support care plans as a last resort when other de-escalation strategies failed. A review process of each PRN psychotropic intervention was undertaken by the person in charge or her deputy to ensure administration was appropriate in each case. Most staff had completed training in care of residents with dementia and further training was scheduled for staff who had not yet attended this training in the days following this inspection. The inspector observed that staff responded to residents with behaviours and psychological symptoms of dementia (BPSD) in a sensitive, person-centred and compassionate way and residents responded positively to the techniques they used. Residents with BPSD were referred appropriately to the psychiatry of older age services.

There was a centre-specific restraint policy which aimed for a restraint free environment. Risk assessments were completed to ensure each resident's safety while using a bedrail. Bedrails were implemented when alternative equipment trialled failed to meet residents' needs. Arrangements were in place to ensure regular review of appropriateness of bedrail use was implemented since the last inspection in July 2016. Equipment trialled as a less restrictive alternative to bedrails did not currently include partial-length bedrails for residents who requested bedrails to support their mobility while in bed. Low-level beds, foam floor mats and sensor alert equipment were used as alternatives to bedrails for a number of residents. Some residents used lap belts, which were attached as part of their assistive chair and was used to promote their safety.

The provider was the agent for collection of 15 residents' social welfare pensions. The accounting process was demonstrated by the financial controller for the group. The procedures and processes for collection of these residents' social welfare pensions on their behalf by the provider were transparent and was subject to annual audit. Residents or their relatives on their behalf were provided with monthly statements of accounts. The centre maintained small amounts of money for some residents' day to day expenses in safekeeping on their behalf. This money was kept in a locked safe. All lodgements and withdrawals were documented in a ledger and a running balance was maintained for each resident. The inspector checked a sample of documented balances against money held and found them to be accurate in each case. All entries were signed with two signatures. The system in place was found to be sufficiently robust to protect residents and staff.

Judgment:
Compliant

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):

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

Findings:

Findings on this inspection demonstrated that the health and safety of residents, staff and visitors was protected and promoted. The provider has comprehensively addressed all actions in the action plans in relation to fire safety found on inspections carried out by the Health Information and Quality Authority (HIQA) in January 2016.

There was a up-to-date safety statement available for the centre. The risk management policies as required by regulation 26 were in place. The policy informed practices in relation to residents at risk of self-harm, violence and aggression, abuse and unexplained absence and were demonstrated in practice. A risk register was maintained that referenced identification and assessment of risks with controls to prevent potential adverse incidents to residents, visitors and staff. There was evidence that this register informed a dynamic process of risk management in the centre. The clinical risk register included clinical risks such as residents using restraint and bedrail and smoking among others. Safety aprons to protect vulnerable residents who smoked were available in the smoker's room on each floor. Vulnerable residents requiring supervision whilst smoking were supervised appropriately. The inspector observed that measures were been taken by maintenance staff during this inspection to strengthen controls in place to ensure the sluice rooms were secured at all times to prevent unauthorised access.

Health and safety and risk management was a standing agenda item on meetings at all levels. A Health and Safety committee meet regularly. The meetings were minuted. Review of the minutes from the last meeting held in November 2016 referenced discussion and actions taken to address actual and potential internal and external risks. For example, safety interventions were implemented to reduce risk of falls for specific residents and to address potholes in the surface of external roadways around the centre. The centre had access to the group's maintenance department and a full time maintenance person worked on-site to ensure risk was minimised. The inspector saw that a schedule of inspections were undertaken by the maintenance person and where deficits were identified, appropriate remedial actions had been completed or were underway.

All incidents and accidents involving residents, staff and visitors were logged. They were reviewed and addressed in the first instance by the person in charge and were then forwarded to the provider. There was evidence of learning from any serious incidents involving residents with corrective actions and controls to prevent recurrence.

On this inspection, fire doors and exits were unobstructed and ramps and handrails were in place external to fire exits to ensure residents with reduced mobility could exit safely. All residents had evacuation risk assessments completed and documented. Fire safety management checking procedures were in place and no gaps were observed in these records. Servicing of the fire panel, alarm, emergency lighting, directional signage and smoke/heat sensor equipment had been completed. Documentation reviewed confirmed they were in working order. Equipment including fire extinguishers and blankets were available at various points throughout the centre. Fire evacuation drills were completed at regular intervals and reflected testing of day and night-time resources and conditions to ensure residents could be safely evacuated in an emergency. Fire safety training was

completed by all staff, as confirmed by the staff training records and staff spoken with by the inspector regarding the emergency procedures in the event of a fire. Some residents' bedroom doors were held open by various items of equipment. The maintenance team were testing sensor equipment which would meet residents' wishes to keep their bedroom doors ajar and ensure these doors would close on activation of the fire alarm. Arrangements were in place to ensure these residents safety needs were met in the interim.

The centre was visibly clean. Hand hygiene facilities were located throughout the premises. Environmental cleaning procedures in relation to bedroom floor cleaning did not meet best practice procedures. This finding was already identified by the provider and the person in charge. A revised cleaning process including a change in the equipment used was in process and scheduled for imminent implementation. The procedures for segregating clean and soiled linen in the centre's laundry required improvement to reflect evidence-based practice. Missing and damaged paint on wall surfaces in the laundry and stained, cracked and broken tiles on the flooring in the laundry and drying room areas did not ensure this environment could be cleaned effectively. Surfaces were also observed to be dusty. Some residents' wheelchairs were soiled and required cleaning. An infection control policy informed procedures for management of communicable infection and infection outbreak to guide and inform staff. Most staff including cleaning and laundry staff had attended training on infection prevention and control.

Judgment:
Substantially Compliant

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
A medicine management policy was in place to inform safe medication practices. The inspector observed that residents' medicines were stored appropriately including medicines controlled under Misuse of Drugs legislation and medicines requiring refrigeration. Balance checking of stock of controlled medicines and refrigerator temperatures was consistently completed. Residents' prescribed medicines were reviewed at least on a three-monthly basis. Administration of specified medicines such as antibiotics and psychotropic medicines was tracked as part of clinical information collated and reviewed by the person in charge. The person in charge completed medicine management audits at regular intervals. Deficits identified were addressed in

action plans to completion.

The inspector observed medicine administration to residents on this inspection. The nurse administered residents' medicines on a individual basis from the drug storage trolley and recorded those taken by residents as prescribed in line with professional guidelines. Some areas requiring improvement were identified

- nursing staff were administering medicines to some residents in a crushed form although it had not been specifically indicated for relevant medicines on the prescription. A general instruction to crush medicines was indicated on the top of the prescription document.

- nursing staff were administering medications prescribed for PRN (a medicine only taken as the need arises) use, although the maximum permissible amount of medicines was not consistently indicated on the prescription. This finding was identified in an action plan from the last inspection in July 2016 and is actioned in outcome 11 of this report.

While the medicine trolley was locked and secured to the wall in one unit on the first floor, it was stored in an open alcove area on a circulating corridor. This process required review to ensure storage of medicines reflected best practice procedures.

Procedures were in place to record the date of opening of residents' topical creams/ointments and oral liquid medicines to ensure they were not used beyond the timescales recommended by the manufacturer. Procedures were also in place to ensure medicines no longer used by residents in the centre were removed from the medicines trolley and discarded appropriately.

The pharmacist dispensing residents' medications was facilitated to fulfil their obligation. Residents had access to a local pharmacist and the pharmacist was available to meet with residents as they wished. The pharmacist undertook regular audits of medicine management procedures in the centre.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents

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

Theme:
Safe care and support

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

Findings:
A record of all incidents and accidents to residents that occurred in the centre was maintained and records since Jan 2016 were reviewed by the inspector. The person in

charge was aware of the legal requirement to notify the Chief Inspector regarding specified accidents and incidents that occurred to residents. To date and to the knowledge of the inspector, all relevant incidents have been notified to the Chief Inspector by the provider and person in charge.

A quarterly notification report was forwarded to HIQA referencing details of required information up to the end of 2016 including use of restraint in the centre.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs

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

Theme:
Effective care and support

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

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

Findings:

There were 61 residents accommodated in the centre on the days of this inspection. Many residents had complex care needs including dementia and acquired brain injury. 28 residents had assessed maximum dependency needs, nine residents had assessed high and 12 residents had assessed medium dependency needs. 12 residents had low dependency needs. 38 residents had dementia.

Residents had good access to a local general practitioner (GP) service. A GP visited the centre routinely on a weekly basis. Residents also had access to allied health professionals including occupational therapy, physiotherapy, speech and language and dietician services. Specialist medical services including palliative care and psychiatric services attended residents in the centre. Residents' documentation confirmed they had timely access to these services as necessary in addition to support to attend out-patient appointments. Residents spoken with by the inspector expressed their satisfaction with the care they received in the centre and from medical and allied health services. Recommendations made by these services were documented in residents' care plans as found on the inspector's review of a sample of residents' care plans. As discussed in outcome 9, some areas of medicine administration by nurses did not reflect professional practice guidelines.

The inspector found on this inspection that arrangements were in place to meet residents' assessed healthcare needs. Residents' care needs were assessed on admission

and regularly thereafter using validated risk assessment tools. This information informed care plans that described the care interventions to be delivered to meet each resident's identified needs. Since the last inspection in July 2016, all residents' oral health was assessed and regularly reviewed. The inspector observed that two residents were referred to a dentist following assessment in the centre by staff. The inspector found that the information in care plans was person-centred and clearly informed care needs. However, improvement was required to the content of some behavioural support care plans as discussed in outcome 7 and activity care plans for residents with needs that were not met in group activity arrangements as discussed in outcome 16. Arrangements were in place to ensure care plans were reviewed on a three to four-monthly basis or more often in response to residents' changing needs. While there was evidence that residents' care was discussed with them or their relatives where appropriate, this consultation process was not documented.

Residents' risk of unintentional weight loss was assessed on admission and regularly thereafter. Residents' weights were checked on a monthly basis or more often to monitor treatment interventions and progress more closely.

Resident falls were closely monitored. Residents' risk of falling was assessed, reviewed on a four monthly basis and reassessed following a fall incident. Data on resident falls was collated, analysed and used to inform risk management and staffing resources. The inspector observed that there was a low incidence of residents falling and sustaining injuries requiring hospital treatment. Residents at increased risk of falling wore hip protectors and were provided with increased staff supervision, low level beds and floor mats to mitigate risk of injury. Some residents used sensor alert mats however they were required to purchase this equipment as discussed in outcome 3. The provider advised the inspector that this arrangement would not hinder residents' access to this equipment if it was needed to mitigate their risk of falls.

The inspector was told by the person in charge that no residents had pressure ulcers in the centre on the day of this inspection. Two residents had wounds which were being managed in the centre with the support of a tissue viability nurse specialist. The inspector reviewed pressure ulcer preventative procedures and wound care procedures in the centre. Assessment of risk of skin breakdown was completed for each resident on admission and regularly thereafter. Equipment such as pressure relieving mattresses and cushions in addition to care procedures including repositioning schedules were used as prevention strategies. The inspector reviewed a repositioning schedule for a resident at high risk of altered skin integrity due to pressure. Although completed, repositioning frequency required was not clearly described and the consistency with which it was completed varied. Arrangements were in place to ensure any residents with wounds were assessed by staff using an appropriate measurement system which assessed size, type, and exudate and included a treatment plan to inform care procedures. Wounds were photographed to monitor progress. Tissue viability, dietician and occupational therapy specialists were available as necessary to support staff with management of wounds that were slow to heal or deteriorating.

There were procedures in place to promote residents' good health and to prevent unnecessary hospital admissions. Residents' health was promoted by annual influenza vaccine, regular vital sign monitoring and regular exercise as part of their activation

programme. One residents' GP replaced their percutaneous endoscopic gastrostomy (PEG) feeding tube as necessary negating their transfer to hospital for this procedure. Staff were trained to provide subcutaneous fluid administration to treat residents with acute episodes of dehydration.

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:

Residents were accommodated over two floors in the centre premises, arranged into three separate units. The inspector found that some aspects of the design and layout of the units on the first floor did not meet their stated purpose in terms of communal facilities provided for residents and insufficient shower/bath facilities in one unit on the first floor. A lift was provided for transportation between floors. However, the doors to the lift required manual operation and as such the lift was not easily accessible for most residents. The lift could not accommodate a stretcher or bed. The provider had already identified these areas as requiring improvement and had plans to extend and refurbish the first floor accommodation at an advanced stage. Residents' current accommodation was provided in a variety of single and twin bedrooms of varying sizes. The bedrooms provided sufficient space for residents' mobility and storage needs. Some of the single bedrooms had en-suite shower, toilet and a wash basin and others have either a wash basin or a toilet and wash basin facilities.

Residents' bedrooms were personalised with their own photographs, personal items and ornaments. A spacious communal dining room and two sitting rooms were provided on the ground floor. Some residents also chose to spend time sitting in a seated area in the centre's reception. Residents on St Patrick's unit on the first floor had access to a communal dining room and a communal sitting room. Residents on St Oliver's unit on the first floor had access to a communal sitting/dining room. The variety of and space available in communal areas in both units on the first floor precluded all residents sitting or dining together at the same time. There was no alternative area that could be freely accessed by residents to meet their relaxation or dining needs, this finding impacted

negatively on their quality of life and how their needs were met. The inspector observed that the sitting/dining area in St Oliver's unit was over crowded and very noisy. A safe and secure external garden was provided for residents on the ground floor and an external balcony courtyard was provided for residents in each unit on the first floor. A smoker's room was located on each floor for residents who wished to smoke. A spacious oratory and hairdressing facility were located on the ground floor. The centre was warm and well ventilated. Refurbishment of one of the residents' communal sitting rooms on the ground floor was completed and a lighted electric fire fitted in this area created an comfortable ambience.

Areas of the centre accessible to residents were found to be well maintained and in a good state of repair. However, improvement was required to the laundry area which occupied two rooms, one of which was designated for washing and the other for drying clothes. Paintwork on walls required attention and floor tiles were found to be stained and in disrepair in both rooms in the laundry. The layout and design of this facility also required review to ensure the arrangements in place reflected evidence-based laundry practices. The paint on surfaces of bedpan and urinal racking units in all three sluice areas was cracked and peeling. These findings did not ensure effective cleaning could be achieved.

Handrails were fitted in communal circulating corridors and on both sides of corridors on the first floor with ramped floor surfaces. Sufficient grab-rails were not fitted in communal or en-suite showers/bathrooms and toilets. A programme to fit these assistive devices was commenced on the days of this inspection. Adequate storage facilities were available for residents' equipment such as assistive chairs, hoists and commodes. An action from the last inspection was nearing completion with a number of residents' assistive chairs repaired or replaced. The inspector observed that one resident's assistive wheelchair still required attention to address tears in the fabric surface on the arm rests.

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 complaints policy available to inform procedures and practices in the centre. The complaints procedure was in line with the requirements of the Regulations and included an appeals process. The person in charge was the designated person to

address complaints. The complaints procedure was on display in the centre and was summarised in the residents' guide document. Advocacy services were available and details was included in the residents' guide. There was evidence that advocacy services provided were involved in assisting some residents in the centre.

A complaints log was maintained in the centre and recorded verbal and written complaints. All complaints were investigated and the investigation details and actions taken were documented. The satisfaction of complainants was also ascertained and documented. The inspector was informed that there were no active complaints under investigation at the time of this inspection.

Residents spoken with by the inspector on the days of this inspection and feedback received by the Authority in pre-inspection resident and relative questionnaires supported a finding that residents or/and their relatives knew who to approach if they were dissatisfied with any aspect of the service. They also expressed confidence that their concern would be addressed.

Judgment:
Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:

A policy document was in place to inform care of residents at the end-of-life stage of their lives. The person in charge told the inspector that no residents were receiving end-of-life care on the days of inspection. Community palliative services attended the centre to support residents with pain and symptom management on referral by staff. Palliative care services were supporting staff with one resident's pain management. The pain assessment tool used was being revised to ensure it was effective in assessment of pain experienced by residents who had dementia or were non-verbal due to other conditions.

Most residents had made their end of life wishes known to staff and this information was documented in their care plans. The remaining residents had not made decisions regarding their end of life plans however; there were systems in place for recording same when this information became available. Residents' end of life care plans referenced their spiritual, psychological and physical needs and their wishes regarding the place for receipt of that care.

Arrangements were in place to facilitate residents' families to stay overnight in the centre with them when receiving end-of-life care. Residents are offered use of the centre's oratory for removal and funeral services which the inspector was told some availed of. A church was located within close proximity to the centre. Residents had good access to religious clergy to meet their faith needs.

An annual remembrance service was held to remember residents who had deceased during the year.

A staff nurse in the centre was being supported by the provider to complete a third level qualification in palliative care nursing.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were closely monitored and checked routinely on a monthly basis or more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations made by the dietician and speech and language therapist where appropriate.

Residents had a choice of hot meal for their lunch each day. Eleven residents required diabetic diets and others required the consistency of their food to be modified to safely meet their swallowing needs. Some residents with unintentional weight loss or weight gain were also prescribed specialist diets by the dietician. The inspector observed that residents with specialist dietary and fluid consistency requirements received the correct diets and thickened fluids. While residents on the ground floor were facilitated to dine together at mealtimes, the arrangements and facilities on in St Patrick's and St Oliver's units did not ensure residents could dine together at mealtimes. This findings is discussed and actioned in outcome 12.

There was sufficient numbers of staff available in the dining rooms to support residents at mealtimes in all three units. Staff sat with residents and provided them with

encouragement or discreet assistance with their meal as necessary. The menu was clearly displayed. Alternative meals and drinks were available to residents who wanted an alternative to the menu on the day. This finding was confirmed by the chef who discussed alternative meals provided for residents including alternatives to the menu on the days of inspection. Some residents expressed dissatisfaction with the menu provided to the inspector and in pre-inspection questionnaires given to residents prior to this inspection. The provider and person in charge had already identified this feedback from residents and had taken action to review the menu provided in consultation with residents. Residents expressed their satisfaction with the revised menu choices to the inspector. The dietician was also involved to ensure the revised menu choices met residents' nutritional needs.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

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

Findings:

Residents were consulted in relation to the running of the centre. This was evidenced by the minutes of residents' meetings and the inspector's discussions with individual residents on the days of inspection. Some examples where residents were involved in planning included refurbishment of the sitting room on the ground floor and residents were facilitated to participate in development and design of the balcony courtyards on the first floor. Residents meetings were convened at regular intervals and were minuted. An advocate attended the centre on a weekly basis and brought residents' views to the person in charge on their behalf. The person in charge and her deputy spent significant amounts of each day among residents to gain their feedback on the service provided and to ensure residents' needs were met.

There was a policy of open visiting in the centre with protected mealtimes in line with the residents' wishes. Relatives' feedback confirmed that visitors were made welcome when visiting in the centre. The inspector observed visitors visiting residents on the days of inspection. Many residents expressed their satisfaction with how staff assisted them to go out with their visitors on day trips or for refreshments.

Residents were facilitated to participate in activities in each of the units within the designated centre. A schedule of activities was displayed but could be improved with information regarding the venue and time the activity scheduled was starting. Two activity co-ordinators had responsibility for meeting residents' activation needs in the centre. The co-ordinated activity hours were increased since the last inspection and co-ordinated activities were provided for residents from 10:00 to 20:00hrs each day per week except Sundays. Four staff including the activity co-ordinators had completed courses in an accredited sensory based programme to support meeting the needs of residents with cognitive impairment and dementia. The activity co-ordinators were in the process of completing life histories for each resident. Although residents past interests informed the group activities provided, the inspector observed that there was a high proportion of residents who did not participate in the group activities available on the days of inspection. Many of these residents had one to one or small group sensory activation needs. An activity programme was not individually documented to inform the needs of residents who remained in their bedrooms, and/or had one to one needs. An accredited sensory based activation session was facilitated once weekly for residents. However this frequency and limitations on the number of participants at these sessions did not ensure that all residents with needs for this mode of activation had an opportunity to participate. The inspector also found that while residents' attendance at activities was recorded, their levels of participation and engagement were not consistently recorded. Therefore it was difficult to ensure that some residents were provided with activation that met their interests and capabilities. The inspector saw that five hours each weekday and one hour on Saturdays were assigned by the activity co-ordinator to providing one to one activation for residents. However, there was opportunity during this time for other staff to facilitate a group activity of interest to residents. The inspector observed that residents on the ground floor enjoyed and were engaged during co-ordinated activities but many were sleeping at other times. Two residents told the inspector they experienced boredom in the centre.

The layout and space of communal areas on the first floor did not support residents to meet their recreational needs. The communal sitting/dining room on St Oliver's unit was over-crowded and very noisy. Most residents could not relax in a comfortable chair due to lack of space. The doors to external balcony courtyards were secured and as such prevented residents freely accessing these areas. The lack of sufficient communal space is discussed and actioned in outcome 12.

Residents were facilitated to meet their religious/spiritual needs. Prayers were held each day for residents. Some residents attended Mass in the local church in addition to the Mass celebrated in the centre's spacious oratory. One resident was an active member of the Eucharistic ministry team in the local church. Residents had access to clergy to meet their faith needs. Large notice boards were located in convenient locations advising residents on useful information that may be of interest to them.

The inspector observed that staff got consent from residents for all care activities and gave them choice regarding their daily activities in the centre. The inspector observed staff knocking on residents' bedroom doors and closing doors to bedrooms and toilets during personal care activities. Residents who required assistance with eating were provided with same discreetly. The inspector observed that staff interactions with

residents were respectful, courteous and supportive.

Judgment:

Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector observed that residents could maintain control over their personal possessions and clothing. Each resident had their own personal wardrobe which they had unobstructed access to and had sufficient space in their bedrooms to store their personal belongings. Residents could maintain control over their belongings and they had access to a lockable space to store valuables. The inspector observed that residents could also lock their bedroom doors if they wished.

Residents' clothing was discreetly tagged to prevent loss of any items. Residents spoken with by the inspector expressed satisfaction with the laundry service. The inspector observed that there was a low incidence of lost or mislaid residents' clothing which were resolved to the satisfaction of the residents/relatives concerned.

Residents' clothing was observed to be clean and in good condition. Records were maintained of residents' property and were updated at regular intervals. However, these records did not include details of sensor mats purchased by them.

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):

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

Findings:

The numbers and skill mix of staff were reviewed on this inspection. The provider and person in charge used a staffing calculation tool that took account of residents' dependency levels among other parameters to inform staffing numbers and skills in the centre. Monitoring and analysis of data on resident fall incidents was also used to inform staffing levels and skill mix. Since the last inspection in July 2016, the provider had increased activity co-ordinator hours to meet the activation needs of residents with dementia. Care staff hours were more recently increased on one unit to enhance supervision of residents at high risk of falling. An actual and planned staffing roster was in place. The roster reflected the staff on duty on the days of inspection. Residents spoken with confirmed that staff responded quickly to their call bells and their care needs were satisfactorily met. The inspector also observed that call bells were responded to without delay on the days of this inspection. The feedback in pre-inspection questionnaires confirmed that residents' were satisfied with how their care needs were met by staff. While the inspector was assured that the staffing levels and skill mix provided met residents' needs, review of residents' activation provision was necessary to ensure activities were facilitated to meet all residents' needs.

Staff received an annual appraisal which was used to inform training resources. The assistant director of nursing was mostly rostered on a supernumerary basis and focused her time on supporting and supervising care of residents by staff across the centre. Recruitment policies and procedures were in place to inform practice and were supported by an induction programme for new staff to the centre.

The inspector reviewed staff training records, observed practices and spoke with staff and found that all staff working in the centre had completed mandatory training. Staff training records evidenced attendance by all staff at training in fire safety including participation in simulated evacuation drills, protection of vulnerable adults and safe moving and handling procedures. In addition to mandatory training requirements, the inspector saw that staff were facilitated to attend training to support their professional development to inform and refresh their knowledge and skills to meet residents' assessed needs.

A sample of staff employment files were reviewed by the inspector and were found to be complete as required by Schedule 1 of the regulations. All staff including volunteers were appropriately vetted. Volunteers' roles were stated. The inspector found that all staff were well-informed and knowledgeable regarding residents' needs and their care plan interventions.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
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:	Ratoath Manor Nursing Home
Centre ID:	OSV-0000152
Date of inspection:	16/01/2017
Date of response:	13/02/2017

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 03: Information for residents

Theme:

Governance, Leadership and Management

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

The fees and additional fees to be charged were not documented in some contracts in the sample reviewed.

1. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated

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

centre and includes details of the fees, if any, to be charged for such services.

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

The Registered Provider will attend with its solicitors to the prompt legal review of the contracts for care (including template contracts for care) for all existing and future residents to ensure effective compliance with Regulation 24(2) of the Care and Welfare Regulations as amended and to engage (upon the completion of the legal review) with the contract parties to its contracts for care with a view to the updating of existing contracts for care, where advised or necessary.

Proposed Timescale: 16/03/2017

Theme:

Governance, Leadership and Management

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

The inspector found that residents' agreed contract details did not reference liability by those assessed as being at increased risk of falls for the purchase of a sensor alert mat.

2. Action Required:

Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

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

All contracts of care are currently under review and will be amended to ensure the contract of care includes details of the fees and additional fees if any, to be charged to each resident. Each contract will stipulate the approximate charges for specialised equipment that are not covered under the fee rate.

Proposed Timescale: 30/04/2017

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:

Some items of required information were not consistently recorded for each resident in the directory of residents record.

3. Action Required:

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

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

The resident register has been amended to ensure it includes the information specified in paragraph (3) of schedule 3.

Proposed Timescale: 13/02/2017

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 procedures for segregating clean and soiled linen in the centre's laundry required improvement to reflect evidence-based practice. Missing and damaged paint on wall surfaces in the laundry and stained, cracked and broken tiles on the flooring in the laundry and drying room areas did not ensure this environment could be cleaned effectively. Surfaces were also observed to be dusty.

Some wheelchairs were found to be soiled.

4. 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:

All wheelchairs will be cleaned on a daily basis.

A member of staff has been allocated to clean the laundry on a daily basis.

The laundry facility will be refurbished as part of the extension works but as an immediate action a portable physical barrier has been ordered to segregate the two areas in the laundry and the floor and wall surfaces are scheduled for repair so that they can be cleaned effectively.

Proposed Timescale: 31/03/2017

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:

This process of storing the medicine trolley on one unit on the first floor required review

to ensure storage of medicines reflected best practice procedures.

5. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

The storage of each medicines trolley has been reviewed and a designated area has been allocated for storage. Staff communication session have taken place to remind staff on the procedures for storing the Medicines trolley.

Proposed Timescale: 13/02/2017

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:

While there was evidence that residents' care was discussed with them or their relatives where appropriate, this consultation process was not documented.

6. 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:

The PIC has developed a control document that will show each time a consultation/discussion on the residents care plan has taken place with the resident and/or relative.

Proposed Timescale: 30/04/2017

Theme:

Effective care and support

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

Improvement was required to the content of behavioural support care plans and activity care plans for residents with needs that were not met in group activity arrangements as discussed to ensure they informed care procedures.

7. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the

assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

All care plans of residents that require behavioural support plans are in place and will be evaluated on reviewed at a minimum of 3 monthly. These plans of care are guiding and supporting staff in meeting the needs of the individual residents.

A full review of activates offered to residents is underway. New activities are going to be introduced and time will be allocated for one to one activities for those resident that identify as requiring individual sessions. These sessions will be documented and tracked in the residents care plan. A benefit analysis review will take place every 3 months to ensure wellbeing needs are being consistently met for each resident.

Proposed Timescale: 30/04/2017

Theme:

Effective care and support

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

The frequency of repositioning of residents at risk of pressure related skin injury was not clearly described and the consistency with which this procedure was completed varied.

Nursing staff were administering medicines to some residents in a crushed form although it had not been specifically indicated for relevant medicines on the prescription.

Nursing staff were administering medications prescribed for PRN (a medicine only taken as the need arises) use, although the maximum permissible amount of medicines was not consistently indicated on the prescription.

8. 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:

The PIC has reviewed all residents that require the use of a repositioning chart. Communication sessions have taken place with the care staff re the importance of the documentation and of following of the best practice guidelines on repositioning. The PIC will audit all repositioning charts on a monthly basis. The Staff nurse on each shift will review on a daily basis.

All resident GP's have been requested to document on each individual residents medication kardex what individual medicine is for crushing. The nursing staff with the assistance of the pharmacy will review the medication kardex on a monthly basis to

ensure compliance.

All resident GP's have been requested to document on each individual residents medication kardex maximum permissible amount of PRN medicines. The nursing staff with the assistance of the pharmacy will review the medication kardex on a monthly basis to ensure compliance.

Proposed Timescale: 30/04/2017

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:

Some parts of the design and layout of the premises did not meet the needs of residents on the first floor including:

- sufficient communal facilities and space provided for residents.
- insufficient shower/bath facilities in one unit on the first floor.
- the laundry facilities required improvement
- assistive grab-rails in toilets and showers.
- the lift provided for transportation between floors
- the fabric on one resident's wheelchair was torn

9. 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 wheelchair noted to be ripped has been repaired.

The assistive grab rail installation that was in progress on the day of the inspection has now been completed.

The proposed extension detailed in Appendix A will comprehensively address the issues relating to communal and shower/bath facilities and a new suitably sized lift will be installed with automatic doors.

Proposed Timescale: 31/08/2018

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Improvement was required in the activities provided to ensure all residents needs were met in accordance with their interests and capabilities.

10. Action Required:

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

A full review of activity provision and activity care plans is underway. All residents care plans will show evidence of participation, engagement and wellbeing following activities. They will include both group activities and one to one programmes. The plans for each resident will take into account their likes and capabilities. The programme and care plans will be reviewed on a 3 monthly basis with the key workers, i.e. Activity coordinators, CNMs , Care staff, residents and/or families and PIC.

Proposed Timescale: 30/04/2017

Theme:

Person-centred care and support

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

Residents on the first floor did not have adequate facilities to meet their activation needs.

11. Action Required:

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

The doors to the balcony areas on the first floor are left unlocked and are of a sliding nature to allow ease of access to residents.

The new proposed extension will address all other facilities to meet the activation needs of residents.

Proposed Timescale: 31/08/2018

