Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Oaklands Nursing Home
Centre ID:	OSV-0000260
Centre address:	Derry, Listowel, Kerry.
Telephone number:	068 21173
Email address:	info@oaklandsnh.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bolden (Nursing) Limited
Provider Nominee:	Michael O'Donoghue
Lead inspector:	Caroline Connelly
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	45
Number of vacancies on the date of inspection:	6

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
04 April 2017 10:50	04 April 2017 18:00
05 April 2017 08:45	05 April 2017 17:00

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	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Major
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection. The provider had applied to renew their registration which is due to expire on 08 August 2017. As part of the inspection the inspector met with the residents, the person in charge, the provider, relatives, Clinical Nurse Manager's (CNM,) and numerous staff members. The inspector observed practices, the physical environment and reviewed all governance, clinical and operational documentation such as policies, procedures, risk assessments, reports, residents' files and training records to inform this application. The provider, person in charge and the staff team generally displayed good knowledge of the regulatory requirements and they were found to be committed to providing person-centred care for the residents.

There had been a number of changes to management and governance of the centre

since the previous inspection. The person in charge was new to the centre and had been in post approximately 9 months and an interview had been conducted with her prior to the inspection in the HIQA office. There was also two new CNM's in post and an interview was conducted with them during this inspection. They all displayed adequate knowledge of the standards and regulatory requirements. The CNM's deputised in the absence of the person in charge and the provider is in the centre daily. The inspector was satisfied that there was a clearly defined management structure in place but as the key managers were all new to their roles, effective management systems were being developed but were not yet fully implemented.

A number of quality questionnaires were received from residents and relatives and the inspector spoke to many residents and relatives throughout the inspection. The collective feedback from residents and relatives was one of general satisfaction with the service and care provided. One relative commented that "the person in charges door is always open and she always gives you her time", "we can discuss our relatives care with nursing staff at any time ". Another complimented "the homely atmosphere in the centre and that there is always an air of friendly calm". One relative requested a "faster entrance and exit to and from the centre as it can take a long time for staff to leave visitors in and out of the building". Residents stated that "the staff are kind and caring" I have my own space and it is a good place " One resident said "there was too much noise during dinner time.". this was looked into and discussed further in the body of the report. Family involvement was encouraged with relatives and residents stating they are welcomed at any time. The inspector saw numerous visitors in and out of the centre during the two day inspection. There was a residents committee which facilitated the residents' voice to be heard and this was run by the activity staff. HIQA had received information of concern in relation to the governance of the centre, lack of nursing staff and high turnover of staff. A concern about care practices particularly for residents in bed was also received. These issues were looked into during the inspection and are discussed and actioned under the relevant outcomes of Governance, staffing and residents' rights dignity and consultation.

There was evidence of residents' needs being met and the staff supported residents to maintain their independence where possible. Resident's health and social care needs were met. Residents had comprehensive access to (GP) services, to a range of other health services, and the nursing care provided was found to be evidence-based. Residents could generally exercise choice in their daily life and were consulted on an ongoing basis. Residents could practice their religious beliefs.

The inspector identified aspects of the service requiring improvement. These included, recruitment practices, management systems, a review of staffing levels and skill mix in the evening, medication management and times of administration, times for breakfast, updating contracts of care, staff files and the requirement for all staff to have Garda Vetting. These are discussed under the outcome statements. The related actions are set out in the Action Plan under the relevant outcome.

These improvements are required to comply with 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. The provider was required to complete an action plan to address these areas.

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:
The statement of purpose and function was viewed by the inspector, and it clearly described the service and facilities provided in the centre. It identified the staffing structures and numbers of staff in whole time equivalents. It also described the aims, objectives and ethos of the centre. This ethos was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose included the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007. The arrangements for the management of the centre in the absence of the person in charge, was not included. This was identified to the management team by the inspector during the inspection and was rectified. Following the amendment the updated statement of purpose was found to meet the requirements of legislation.

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:
The centre is owned and operated by Bolden Nursing Limited which consists of three directors. One of the directors is the nominated provider and he is in the centre on a daily basis. Since the previous inspection in May 2016 there have been a number of changes to the governance and management of the centre which included changes to the person in charge. The person in charge was new to the centre and had been in post approximately 9 months and an interview had been conducted with her prior to the inspection in the HIQA office. There was also two new CNM's in post since the last inspection and an interview was conducted with them during this inspection. They all displayed adequate knowledge of the standards and regulatory requirements. The CNM's deputised in the absence of the person in charge. The inspector was satisfied that there was a clearly defined management structure in place. However all the nursing team were new to their posts and were still settling into their managerial roles and management systems were being implemented. The current management systems in place were not sufficiently robust to ensure that the service provided was consistent and effectively monitored. This was evidenced by poor recruitment practices, gaps in mandatory training for staff; ineffective systems for management of complaints and care planning. The person in charge assured the inspector that they were working on all aspects of the issues identified and were implementing new systems now that they were up to full compliment with their staffing levels and had a management team in place. At the time of the inspection the CNM's did not have any supernumerary managerial time and the person in charge did not have day to day administration support.

The lines of accountability and authority were now clear and all staff were aware of the management structure and were facilitated to communicate regularly with management though staff meetings and daily handover meetings held at 14.00hrs daily to discuss all aspects of residents care and any issues in the centre.

Inspectors saw evidence of the collection of key clinical quality indicator data including pressure ulcers, falls, the use of psychotropic medications, bed rails, medication management and administration, the assessment of risk, and health and safety. The inspector saw that there were systems being put in place for monitoring the quality and safety of care provided to residents. These included internal audits and reviews such as falls audits, infection control audit, food and nutrition audit, quality of life audit, person centred care audit, responsive behaviours audit. These audits had taken place in 2016 and 2017 and audit outcomes and corrective actions were documented. The findings of these audits had resulted in some changes to practices particularly around cleaning and responsive behaviours. However the person in charge acknowledged that further actions were required and due to changes in the whole management systems these were ongoing.

There was evidence of consultation with residents and relatives through residents meetings chaired by activity staff, and relative meetings chaired by the person in charge. Inspectors noted that issues raised by residents were brought to the attention of the person in charge and items were followed up on subsequent meetings. Relatives reported that the relatives meeting was a particularly useful format to communicate with the person in charge and the staff.

The inspector saw that the person in charge had completed a comprehensive six monthly review of the quality and safety of care and support in the designated centre since she had taken up post. However an annual review had not been undertaken by the provider in accordance with the standards prior to this. This is a requirement of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. There were a number of aspects of the documentation that required review the inspector noted there was no administration staff available in the centre and requested that this was kept under review in light of the proposed increase in beds.

Judgment:
Non Compliant - Moderate

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:
A Residents' Guide was available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

A sample of residents' contracts of care, were viewed by the inspector. There were new contracts from 2016 and older contracts before then. The inspector found that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and generally outlined all of the services and responsibilities of the provider to the resident and the fees to be paid. The newer contracts also detailed what was included and not included in the fee in a schedule of additional charges. However the schedule of charges did not include all items that incurred additional charges for example specialist mattresses. The inspector also saw that there were a number of older contracts, where the contracts generally had out of date fees included.

Judgment:
Substantially Compliant

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 was new to her role since the previous inspection and displayed good knowledge of the standards and regulatory requirements.
The inspector interacted with the person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis. The inspector was satisfied that she was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations. She demonstrated a commitment to her own professional development and was booked to undertake a managerial and a gerontological qualification later in the year.

Staff, residents and relatives all identified her as the person who had responsibility and accountability for the service and said she was very approachable and were confident that all issues raised would be managed effectively.

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:
This outcome was not generally inspected with the exception of staff files. A sample of staff files were reviewed by the inspector and a number of gaps were identified. Two of the staff files were seen to be missing Garda vetting in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations. One was a recently recruited staff member and the other was in post prior to the 29 April 2016. Following the identification of this, the person in charge assured

the inspector that the recently recruited staff member would be removed from duty until satisfactory Garda clearance was attained. The inspector also found that one staff member who was also recently recruited did not have any references on file and another staff had only one written reference. The person in charge did attain the two written references before the end of the inspection and the other reference remained outstanding. The person in charge assured the inspector that she had audited all staff files and that all other staff had appropriate vetting and the inspector requested written confirmation of that which was received.

Judgment:
Non Compliant - Major

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 had been a change with respect to the person in charge last year and the provider had notified HIQA in relation to same. This demonstrated the awareness of the responsibility to notify HIQA of any absence or proposed absence for 28 days or more.

Deputising arrangements were in place to cover for the person in charge when she was on leave. There are two new CNM's in post since the last inspection. The inspector met and interviewed the CNM's during the inspection and they demonstrated an awareness of the legislative requirements and their responsibilities. They were found to be suitably qualified nurses and were experienced in residential care of the older adult. A number of staff nurses also took responsibility for the centre at weekends, evenings and night time with the backup of the CNM's and person in charge on call as required.

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):
No actions were required from the previous inspection.

Findings:
The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated a good understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The inspector saw that safeguarding training was on-going on a regular basis in-house and the person in charge and one of the CNM's were trainers. Training records confirmed that staff had received this mandatory training however some staff required updating and further training sessions were planned in April. The person in charge and CNM also planned to attend the national safeguarding training and would roll that out to all staff. The training was supported by a policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise. Residents indicated that they could speak to the person in charge or any member of staff if they had any concerns and confirmed that they felt safe and were well looked after in the centre.

The centre generally did not maintained day to day expenses for residents and the inspector saw evidence that financial records were maintained for fees. Residents generally received invoices for care and required extras, but residents and families generally managed their own day to day monies. The provider was made aware of his responsibility to keep invoices on file for all residents.

A policy on managing responsive behaviours was in place. The inspector saw training records and staff confirmed that they had received training in responsive behaviours and specialist dementia training in 2015. However there had been a large number of new staff since that date who had not received training and other staff would benefit from refresher training. The person in charge confirmed that this training is to be arranged and the action for this is under outcome 18 staffing. There was evidence that efforts were made to identify and alleviate the underlying causes of behaviour that posed a challenge. The support of the community psychiatry service was availed of as appropriate to residents needs as was discussed under outcome 1. The records of residents who presented with responsive behaviours were reviewed by the inspector. Behavioural charts were maintained identifying triggers, behaviours and actions taken. However comprehensive responsive behaviour care plans were not in place directing staff on the best approach to take and what effective de-escalation methods to use. The action for this is under outcome 11 Health and Social Care Needs.

There was a centre-specific restraint policy which aimed for a restraint free environment and included a direction for staff to consider all other options prior to its use. However, records confirmed and the inspector saw that there were 26 residents out of the current 45 residents using bedrails at the time of the inspection. The inspector found this was a very large percentage of bedrail usage and this was double the number of bedrail usage at the last inspection, when only 13 residents were using bedrails. The inspector

required this to be reviewed to promote a reduction in the use of bedrails. The inspector noted there was a lack of alternatives such as low profiling beds and although there were some alternatives such as crash mats and bed alarms in use for some residents, this needed to be extended to move towards a restraint free environment. This was discussed with the provider at the end of the inspection and the requirement of him to provide appropriate equipment particularly with a pending extension to the centre. The centre had a risk assessment tool in place to guide the appropriate use of restraint for residents. However, the assessment did not adequately outline the requirement to document measures which had been taken/considered to protect residents prior to using bed rails. Also there was not a detailed risk assessment which assessed the risk of injury of using bed rails and weighed this against the risk of injury of not using bed rails. The system around restraint required review to ensure it was compliant with the national policy.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The inspector saw that the fire policies and procedures were centre-specific. The fire safety plan was viewed and found to be comprehensive. There were notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was provided to staff during 2016 and on 30 March 2017. The person in charge told the inspector and records showed that fire drills were undertaken regularly with different staff in attendance the actions taken and outcome of the fire drill was documented and an evaluation form completed. The last fire drill took place on the 30 March 2017. The inspector examined the fire safety register with details of all services and tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment had been tested in April 2016 and the fire alarm was last tested in February 2017. The inspector saw that there was not evidence of quarterly servicing of emergency lighting, the provider said this was being undertaken on an annual basis but he was unaware of the requirement for quarterly servicing.

Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. There were reasonable measures in place to prevent accidents such grab-rails in toilets

and handrails on corridors. There was a centre-specific emergency plan that took into account all emergency situations and detailed where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The provider has contracts in place for the regular servicing of all equipment and the inspector viewed records of equipment serviced which were up-to-date.

The inspector found the premises was clean and the cleaning staff demonstrated good knowledge of infection control procedures. Personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. Infection control training was on-going and staff demonstrated good hand hygiene practice as observed by the inspector. Arrangements for the disposal of domestic and clinical waste management were appropriate.

The health and safety of residents, visitors and staff were promoted and protected. The health and safety statement seen by the inspector was centre-specific and up-to-date. The risk management policy as set out in Schedule 5 included some of the requirements of Regulation 26(1). The policy covered, the identification and assessment of risks and the precautions in place to control the risks identified. It included the measures and actions in place to control the following specified risks, 1) Abuse and 2) the unexplained absence of a resident. However it did not include 3) accidental injury to residents or staff, 4) aggression and violence, and 5) self-harm and therefore was found not to meet the requirements of legislation. The risk register was up to date and it identified and outlined the management of clinical and environmental risks.

Records viewed by the inspector indicated that not all staff had received up to date moving and handling training. The action for this is under outcome 18 staffing. Hoists were serviced on a regular basis as required by legislation and records of same were seen by the inspector.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The centre-specific policies on medication management were made available to the

inspector. The policies included the ordering, receipt, administration, storage and disposal of medicines. The policies were comprehensive and evidence based. The policies were made available to nursing staff who demonstrated adequate knowledge of this document. Medicines for residents were supplied by a community pharmacy who staff reported provided a very comprehensive service to the centre including the provision of an out of hours service. Staff confirmed that the pharmacist was facilitated to meet his/her obligations as per guidance issued by the Pharmaceutical Society of Ireland and had made themselves available to residents.

Medicines were stored in a locked cupboard or medication trolley. Medications requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range; the temperature was monitored and recorded daily. Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count of controlled medications with the nurse which accorded with the documented records.

Medication administration was observed and the inspector found that the nursing staff did adhere to professional guidance issued by An Bord Altranais agus Cnáimhseachais and adopted a person-centred approach. Staff reported and the inspector saw that no residents were self-administering medication at the time of inspection.

The inspector reviewed a sample of residents' medicine prescription records and they were maintained in a tidy and organised manner, they were clearly labelled, they had photographic identification of each resident and they were legible. There was evidence that residents' medicine prescriptions were reviewed at least every three months by a medical practitioner as well as a pharmacist. Where medicines were to be administered in a modified form such as crushing, this was prescribed in a special instruction sheet included with the medication prescription but was not individually prescribed by the prescriber on the prescription chart. This could lead to errors as not all medications can be crushed and nursing staff could be administering them as such. However, the nursing staff did inform the inspector that the pharmacist supplied them with information on medications that could and could not be crushed and they demonstrated their knowledge of medications that could not be crushed. The maximum dose for 'as required' medicines was specified by the prescriber.

Judgment:
Substantially 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):
No actions were required from the previous inspection.

Findings:
Residents had a choice of General Practitioner (GP) and most residents continued to have their medical care needs met by the GP they had prior to their admission to the centre. Out-of-hours medical cover was available via a doctor on call service. The inspector saw one of the GP's in the centre during the inspection and a sample of medical records reviewed confirmed that resident's were reviewed on a regular basis. Specialist medical services were also available when required. Reviews and on-going medical interventions as well as laboratory results were evidenced. Residents also had access to allied healthcare professionals including physiotherapy, occupational therapy, dietetic, speech and language therapy, dental, podiatry and ophthalmology services. Residents in the centre also had access to the specialist mental health services and were reviewed regularly and as required.

The inspector saw that residents had a comprehensive nursing assessment completed on admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others. There was evidence that non-verbal residents experiencing pain had a pain assessment completed using a validated assessment tool. Pain charts in use reflected appropriate pain management procedures. Each resident had a care plan developed within 48 hours of their admission based on their assessed needs. The inspector reviewed a number of care plans for residents and there were a number of inconsistencies noted. There was evidence of regular review of resident's assessments on a four monthly basis but it was difficult to establish if care plans were changed or updated as a result of these assessments. Some care plans were in place for a number of years, yet some of the core interventions outlined were around initial assessments and therefore were not appropriate. The person in charge showed the inspectors new plans of care that they were moving towards implementing however this process was a work in progress. The management team agreed further work and review was required, to ensure all plans were personalised and to ensure they directed the provision of person centred care. As discussed under outcome 7 Safeguarding and Safety comprehensive plans to meet the needs of residents with responsive behaviours were not in place. Also plans for the social aspects of care required review to ensure they met the needs of all residents particularly the needs of residents in bed which is discussed further under outcome 16 Residents Rights Dignity and Consultation.

Nursing staff told the inspector that a detailed hospital transfer letter was completed when a resident was transferred to hospital. Residents at risk of developing pressure ulcers had care plans and pressure relieving mattresses and cushions to prevent ulcers developing. The inspector reviewed the care of a resident admitted with pressure sores and saw that scientific measurements and assessments were taking place on each dressing change. Staff had access to support from the tissue viability nurse and recommendations she put in place were followed by staff.

There were systems in place to ensure residents' nutritional needs were met, and that the residents received adequate hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis and more frequently if evidence of unintentional weight loss was observed. Residents were provided with a choice of meals at mealtimes and the inspector saw staff assist residents with eating and drinking. This was undertaken in a discrete and sensitive manner. Residents were complimentary about the food provided. Nutritional supplements were administered as prescribed. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. There was evidence of an assessment of residents dietary requirements completed by the chef kept in residents' notes and in the kitchen. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT. The inspector found that the time for breakfast at 07.00 was very early and recommend that this was kept under review.

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

Findings:
A written complaints policy was available in the centre and the inspector saw that the complaints procedure was hung in a prominent place at the entrance to the centre. The complaints procedure identified a complaints appeals process through the assistant person in charge and thereafter to the person in charge. However the procedure did not identify a named complaints officer and it did not identify the person nominated by the provider to ensure all complaints are appropriately responded to. Therefore it did not fully meet the requirements of regulation. The procedure also did not include details for the ombudsman as now required. This was also identified on the previous inspection and remained non-compliant.

The inspector reviewed the complaints log and found the complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon. Residents and relatives the inspector met said that they had easy access to the nurses and the person in charge who to

whom they could openly report any concerns and were assured issues would be dealt with. The person in charge stated that she monitored complaints or any issues raised by being readily available and regularly speaking to residents, visitors and staff. Records showed that complaints documented were dealt with promptly and the outcome and satisfaction of the complainant was recorded as required by the regulations. However, the person in charge and staff were dealing differently with verbal complaints and the inspector was made aware of verbal complaints made to the person in charge that were not documented. This was not in keeping with the requirements of legislation where all complaints should be documented and evidence made available of actions taken and whether the complainant was satisfied or not. Complaints should be used for learning and to inform improvements required in practices,

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
Residents' religious preferences are facilitated through regular visits by clergy to the centre with mass held once a week and administration of sacrament of the sick on a regular basis. There was also a resident priest in the centre and he said an additional mass per week which resident expressed satisfaction with. Residents were facilitated to exercise their civil, political and religious rights. The inspector was told that residents were enabled to vote in national referenda and elections as the centre registered to enable polling. Inspectors observed that residents' choice was generally respected and control over their daily life was facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal room. Inspectors observed that some residents were spending time in their own rooms, watching television, or taking a nap.

Respect for privacy and dignity was evidenced throughout both days of inspection. Staff were observed to knock on doors and get permission before entering bedrooms. Screening was provided in twin bedrooms to protect the residents privacy. Staff were observed communicating appropriated with residents who were cognitively impaired as well as those who did not have a cognitive impairment. Effective communication techniques were documented and evidenced in some residents care plans. Residents were treated with respect. Inspectors heard staff addressing residents by their preferred

names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear and the hairdresser visited regularly.

A number of visitors were observed throughout both days of inspection where staff members knew the names of visitors and vice versa. Staff took time to talk with family members both when they visited and when they rang to enquire about their relative. Visitors told the inspector that they were always made welcome and that there were plenty areas in the centre to visit in private if they wished to. They said that if they any concerns they could identify them to the person in charge and were assured they would be resolved. Questionnaires received from relatives and residents were generally complimentary about the care and service received.

Residents had access to the daily newspaper and residents were observed enjoying the paper. Residents had access to radio, television, and information on local events
There was an active residents' committee which met regularly. Photographs of the committee members were displayed in the entrance hall. Minutes from these meetings demonstrated that there was good attendances at the meetings and a variety of topics were discussed. One resident spoke of their involvement in the committee to the inspector and said they found it a useful forum to have their say in the running of the centre. There was evidence that residents with dementia were consulted with and actively participated in the committee. The person in charge had held a meeting for relatives and feedback from this was positive.

There were two care staff allocated to the function of activity co-ordinators on a part time basis that fulfilled a role in meeting the social needs of residents and the inspector observed that staff generally connected with residents as individuals. There was a programme of activities available to residents which included art, flower arranging, bingo, sing-songs, exercise sessions religious activities and other more individualised activities. Residents and relatives told the inspectors how much they enjoyed the activities. However a number of residents told the inspector and identified it on the questionnaires and in the residents committee that they would like some live music. The person in charge said they were sourcing same and had planned for a harpist to visit the centre. The inspector observed that residents were free to join in an activity or to spend quiet time in their room. However as identified on the concern received by HIQA there was a lack of activities and social stimulation for a number of residents who spent the day in bed. The inspector observed staff undertaking regular checks on these residents but other interactions were limited and residents spent long periods of the day with little social interaction. The inspector checked the care plans for these residents and a more comprehensive social stimulation and care plan was required. This is outlined under care planning in Outcome 11.

Inspectors observed that residents' choice was generally respected and control over their daily life was facilitated, however breakfast was found to be very early served from 7am. Some residents identified that they did not wish to have breakfast that early and a review of times was required.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
There had been a high turnover of staff since the previous inspection including the senior nursing team, a number of nurses and care staff. There is now a new person in charge and two new CNM's and a number of new nurses and care staff. The person in charge said it was difficult at the start and the centre went through an unsettled period. She stated that she now feels she has a stable and effective team with two further nurses recruited to join the team in the next number of months. Residents and relatives generally spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector sat in on the handover meeting that took place at 14.00hrs on the first day of the inspection. The meeting proved a very effective mode of communicating residents' needs with the whole team and an opportunity for care staff to feed back to the person in charge and nursing staff.
The inspector found staff to be well informed and knowledgeable regarding their roles, responsibilities and the residents' needs and life histories. There was evidence that residents knew staff well and engaged easily with them in personal conversations.

Mandatory training was in place and some staff had received up to date training in fire safety, safe moving and handling and safeguarding vulnerable persons. However the inspector found that not all staff had up to date mandatory training in responsive behaviours and some staff required moving and handling refresher training. Other training provided included restraint procedures, dementia specific training, infection control, end of life, continence promotion, food and nutrition hydration and the management of dysphagia. Nursing staff confirmed they had also attended clinical training including blood- letting and wound care. The inspectors saw that other training courses had been booked and were scheduled for the coming months.

Duty rosters were maintained for all staff and during the two days of inspection the number and skill-mix of staff working during the day was observed to be appropriate to meet the needs of the current residents. However skill mix in the evening and night time required review. The inspector saw there was only one nurse on duty for up to 51 residents. The night nurse had to do the night time medication round for the 51 residents. If there was a resident unwell or at end of life the nurse could be called away or disturbed from the medication round which could lead to errors or delays in the administration of medications to a number of residents. The inspector found that this skill mix was not adequate to ensure the nurse administered the medications safely without interruption.

The inspector saw that current registration with regulatory professional bodies was in place for all nursing staff. A sample of staff files was reviewed and as outlined and actioned under outcome 5 Records; these were not complaint with the Regulations and did not contain all the items listed in Schedule 2. Two of the staff files were seen to be missing Garda vetting, one was a recently recruited staff member and the other was in post prior to the 29 April 2016. Following this being identified the person in charge assured the inspector that the recently recruited staff member would be removed from duty until satisfactory Garda clearance was attained. The inspector also found that one staff member who was also recently recruited did not have any references on file and another staff had only one written reference. The person in charge did attain the two written references before the end of the inspection and the other reference remained outstanding. The person in charge said all other staff had appropriate vetting and the inspector requested written confirmation of that. The inspector was not satisfied that there were sufficiently robust recruitment practices in place in the centre and this required immediate review.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Health Information and Quality Authority

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Action Plan

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

Provider's response to inspection report[1]

Centre name:	Oaklands Nursing Home
Centre ID:	OSV-0000260
Date of inspection:	04/04/2017
Date of response:	05/05/2017

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although the person in charge had completed a six monthly review since she took up post. An annual review had not been undertaken by the provider in accordance with the standards prior to this. This is a requirement of Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013

1. Action Required:

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

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
An Annual review of the Quality & Safety of Care is underway and will be completed before the proposed timescale.

Proposed Timescale: 30/06/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The current management systems in place were not sufficiently robust to ensure that the service provided was consistent and effectively monitored. This was evidenced by poor recruitment practices, gaps in mandatory training for staff; ineffective systems for management of complaints and care planning. At the time of the inspection the CNM's did not have any supernumerary managerial time and the person in charge did not have day to day administration support.

2. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
An administration assistant commenced on Monday 22nd of April and will work Monday to Thursday 1000 to 1500 and will be available for extra hours on Friday as required.
A robust telephone system is being sourced which will enable the nursing staff and PIC to have hand held telephones.
Three staff nurses have been recruited and will be available on the roster, before the end of May. This will enable the PIC to roster the CNM's for superneumary time.
All staff files have been checked by the PIC and any gaps in mandatory training have been addressed. As discussed with the inspector on the day, verbal and written complaints will be documented using the same format.
As was discussed with the inspector on the day, the PIC is in the process of changing over our care plans to a more manageable new system and is ongoing, in doing so all residents will be reviewed in this process.

Proposed Timescale: Ongoing

Proposed Timescale: 05/05/2017

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 inspector found that the schedule of charges in the contracts of care did not include all items that incurred additional charges for example specialist mattresses. The inspector also saw that there were a number of older contracts, where the contracts generally had out of date fees included.

3. 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:
An audit of the contracts of care is underway and extras have been added to include mattresses and electric beds. Any old contracts which have been replaced by new contracts have been removed from the resident's files.

Proposed Timescale: 29/05/2017

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:
A sample of staff files were reviewed by the inspector and a number of gaps were identified. Two of the staff files were seen to be missing Garda vetting in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations. The inspector also found that one staff member who was also recently recruited did not have any references on file and another staff had only one written reference. The person in charge did attain the two written references before the end of the inspection and the other reference remained outstanding.

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

Please state the actions you have taken or are planning to take:
The Garda vetting on the member of staff who was recruited before the PIC took up position has been sent for and we surmise this will be with us within the next two weeks. The vetting has been sent for the other member of staff who has since left her post at Oaklands.

The outstanding reference has been attained and has been sent to our inspector.

Proposed Timescale: 29/05/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records confirmed and the inspector saw that there were 26 residents out of the current 45 residents using bedrails at the time of the inspection. The inspector found this was a very large percentage of bedrail usage and was double the number of bedrail usage at the last inspection when only 13 residents were using bedrails. The inspector noted there was a lack of alternatives such as low profiling beds and although there were some alternatives such as crash mats and bed alarms in use for some residents, this needed to be extended to move towards a restraint free environment. The centre had a risk assessment tool in place to guide the appropriate use of restraint for residents. However, the assessment did not adequately outline the requirement to document measures which had been taken/considered to protect residents prior to using bed rails. Also there was not a detailed risk assessment which assessed the risk of injury of using bed rails and weighed this against the risk of injury of not using bed rails. The system around restraint required review to ensure it was compliant with the national policy.

5. 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:
This enables us to continuingly assess the risk of using bedrails against the risk of not using them.
The original number of residents using bedrails included residents who used only one rail which was generally being used as a leverage to move around and get up out of bed, these have been taken out of the numbers as they are not used as restraint. Also 3 of our residents have low profiling beds and all other residents were re-assessed, some of our residents had bedrails as a temporary measure whilst they were ill who no longer require them.
We have 11 residents on the restraint register as requiring bedrails as opposed to the original number of 26.

Proposed Timescale: 15/05/2017

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 risk management policy did not include 1) accidental injury to residents or staff, 2) aggression and violence, and 3) self-harm and therefore was found not to meet the requirements of legislation.

6. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
The risk policy is in the process of being updated to include the afore mentioned policies.

Proposed Timescale: 29/05/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The emergency lighting was not serviced on a quarterly basis as required by legislation.

7. Action Required:
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
The electrician for the Home has been contacted and will carry out the quarterly service of the emergency lightning.

Proposed Timescale: 15/05/2017

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:
Where medicines were to be administered in a modified form such as crushing, this was prescribed in a special instruction sheet included with the medication prescription but was not individually prescribed by the prescriber on the prescription chart. This could lead to errors as not all medications can be crushed and nursing staff could be administering them as such.

8. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist

regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
The PIC is liaising with the pharmacy and the GP with regards to the residents who have been prescribed modified medication. The required individual documentation for each resident and each drug to be modified will be put in place.

Proposed Timescale: 29/05/2017

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:
Inconsistencies were seen in the care planning process, it was difficult to establish if care plans were changed or updated as a result of four monthly assessments. Some care plans were in place for a number of years, yet some of the core interventions outlined were around initial assessments and therefore were not appropriate. Comprehensive plans to meet the needs of residents with responsive behaviours were not in place. Also plans for the social aspects of care required review to ensure they met the needs of all residents particularly the needs of residents in bed. The whole system of care planning required review to ensure they directed person centred care for the residents.

9. 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:
As discussed on the day of the inspection, we are in the process of changing over our care plans to more manageable, straight forward and more person centred friendly care plan package. This is ongoing and as each residents plan of care is being changed over a full review of the residents holistic care is being re assessed. New plans of care to effectively manage responsive behaviours will be introduced for the residents who require them in the changeover. The social aspect of care were being documented in the activity folders along with the all the activity assessments and life stories, these will remain in the Activity folder. A Social activity care plan will be added to the new Activities of living care plans for all residents.

Proposed Timescale: Ongoing

Proposed Timescale: 05/05/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure did not identify a named complaints officer and it did not identify the person nominated by the provider to ensure all complaints are appropriately responded to. Therefore it did not fully meet the requirements of regulation. The procedure also did not include details for the ombudsman as now required. This was also identified on the previous inspection and remained non-compliant.

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

Please state the actions you have taken or are planning to take:
The complaints procedure has been amended and now contains the required information.

Proposed Timescale: completed 28/04/2017

Proposed Timescale: 28/04/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge and staff were dealing differently with verbal complaints and the inspector was made aware of verbal complaints made to the person in charge that were not documented.

11. Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:
All complaints verbal or written will be documented on our complaints form, all complaints are taken seriously and will be dealt with as per our policy. Any changes in care to our residents proceeding from an investigation of a complaint will be reflected in the resident's assessments and plan of care.

Proposed Timescale: Effective immediately

Proposed Timescale: 05/05/2017

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:
There was limited social stimulation and interaction for a number of residents that due to their physical conditions spent the day in bed.

12. 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:
The residents who are nursed in bed do receive social stimulation and are checked hourly and often more regularly. Documentation of the social interactions will be documented in more detail to reflect the interaction they receive, the PIC and our activity staff are looking into different ways for us to stimulate and interact with our residents in bed in a more effective manner. This is ongoing.

Proposed Timescale: Ongoing

Proposed Timescale: 05/05/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Breakfast time was seen to be very early and there was not evidence if residents had a choice in breakfast time.

13. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
Breakfast times have been changed; night staff will no longer start serving breakfast to the residents. The day shift will start to serve breakfast from 0745. The nutrition care plan which is included in the new Activities of Living plan of care will include the resident's wishes.

Proposed Timescale: New routine to start from 03/05/2017

Proposed Timescale: 03/05/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector requested that the skill mix of staff in the evening and night time required review. The inspector saw there was only one nurse on duty for up to 51

residents. The night nurse had to do the night time medication round for the 51 residents. If there was a resident unwell or at end of life the nurse could be called away or disturbed from the medication round which could lead to errors or delays in the administration of medications to a number of residents. The inspector found that this skill mix was not adequate to ensure the nurse administered the medications safely without interruption.

14. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The staffing levels are under review at present, the PIC has assessed the dependency levels versus staffing levels, and we do have the required amount of skill mix as per our Barthal scores. However, we are looking into reintroducing the twilight shift when we reach maximum capacity. A Clinical Nurse Manager is rostered on duty everyday of the week and is available to stay and work extra hours if required to support the night shift, the PIC is also available if required.

Proposed Timescale: Ongoing

Proposed Timescale: 05/05/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspector found that not all staff had up to date mandatory training in responsive behaviours and some staff required refresher training in moving and handling.

15. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
Manual handling training has been booked for the 29th May 2017. Training in responsive behaviours will commence from June 2017. All staff will have received responsive behaviour training by the end of June.

Proposed Timescale: 30/06/2017