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:	Rathkeevan Nursing Home
Centre ID:	OSV-0000271
Centre address:	Rathkeevin, Clonmel, Tipperary.
Telephone number:	052 618 2000
Email address:	rathkeevinnursing@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Drescator Limited
Provider Nominee:	Liam Long
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	53
Number of vacancies on the date of inspection:	8

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:
13 September 2017 07:30	13 September 2017 17:30
14 September 2017 07:30	14 September 2017 16:30

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	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Substantially Compliant
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	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of a two day announced inspection to inform a decision for the renewal of registration. Rathkeevan Nursing Home is located in a rural location outside of Clonmel town. The centre was purpose built single story premises that was first opened in 2001. Accommodation provided consists of 47 single occupancy and seven twin all en-suite bedrooms. It is set in a large grounds with three enclosed outdoor garden areas.

On the days of inspection there were 53 residents living in the centre. Each bedroom contained suitable en-suites with wheelchair accessible showers. There were televisions, telephone and a sufficient space for the storage of personal belongings which included a secure locker in each bedroom. The centre also contained a number of other rooms including three sitting rooms, dining rooms, treatment room, visitors room, hairdressing room, assisted bathroom, a laundry, a small library, an oratory and a number of offices.

As part of the inspection process, the inspector met with residents, staff members, the general manager (GM), the administrator, the person in charge and the provider representative. The inspector observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident/incident logs. Residents told the inspector that they were happy living in the centre and that they felt safe there. Overall staff were able to demonstrate good knowledge of the residents' care needs when speaking with the inspector.

There were 17 outcomes monitored as part of this inspection, 12 of the 17 outcomes were compliant and three outcomes substantially compliant with the regulations. There were two outcomes deemed to be moderately non-compliant; health and safety and risk management and medication management. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed 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.

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 dated as reviewed most recently in September 2017 that described the service that was provided in the centre. The services and facilities outlined in the statement of purpose and the manner in which care was provided, reflected the diverse needs of residents. The statement of purpose contained all of the information required by schedule 1 of the regulations and was reviewed annually. There was a copy made available to residents and their representatives and a copy was also available near the main entrance to the centre.

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 an effective management team in place as evidenced by the level of

compliance identified in this inspection and the on-going improvements in the centre. The general manager (GM) had been employed in the center for 11 years and was very committed to ensuring an excellent standard of service provision. The person in charge who was more recently appointed to this post, was supported by the GM who was also a person participating in management (PPIM). The GM had responsibility for the non-clinical management of the centre, particularly health and safety and human resources. The GM was a registered physiotherapist and also provided some physiotherapist services to residents. The inspector observed a good working and supportive relationship between the person in charge, the provider representative and the GM. The was also a senior staff nurse (PPIM) available to support the person in charge in his role. The person in charge and the PPIM's reported to the provider representative through regular management meetings and the provider representative was always available when required. Staff to whom the inspector spoke were familiar with the organisational structure of the centre. The PPIM's and person in charge had excellent oversight of the service and there was clear support from the provider representative. The person in charge informed the inspector that he had adequate autonomy to meet his responsibilities under regulation. For example he had implemented a number of quality improvement initiatives including the new healthcare assistants' care reporting records, the establishment of the end of life care group and the nutrition matrix. Further details of these initiatives are further outlined under various outcomes of this report.

The inspector interviewed the person in charge and PPIM's. They explained their areas of responsibility and were found to be clinically knowledgeable and resident oriented, in their approach. They were aware of the regulations governing the sector and the national standards. Evidence of consultation with residents was clearly available in a sample of residents care plans, residents' survey results and minutes of residents' meetings. Relatives and residents spoken with by the inspector were very complementary of their experience of care and facilities in the center. The inspector was informed that resources were available to ensure on going premises upkeep and for the continuous professional development of staff. Supervision and appraisal of staff was on-going. The annual review of the safety and quality of care had been completed for 2016. The person in charge had made this report available to the inspector and to residents.

There was evidence of meetings with staff and regular meetings were held with residents and the person in charge was known to residents and relatives to whom the inspector spoke with. From a review of the minutes of residents meetings it was clear that issues identified were addressed in a timely manner and that the person in charge was proactive in addressing any concerns or issues raised. Where areas for improvement were identified in the course of the inspection both the person in charge and the provider representative demonstrated a conscientious approach to addressing these issues and a commitment to compliance with the regulations. For example, there had been improvements required in relation to some paint work in the smokers room and queries in relation to additional smoke detectors identified on the first day of inspection. However, the inspector noted that these issues had been remedied by the second day of the inspection.

There was also evidence of good consultation with residents and relatives via resident/relative satisfaction surveys that were provided as part of this registration inspection. It was of note that the person in charge and staff were identified as being

very supportive and approachable by respondents to these questionnaires.

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:
The inspector reviewed a sample of residents' contracts of care. The inspector noted that contracts had been signed by the residents/relatives and found that the contract was clear, user-friendly and outlined the services and responsibilities of the provider to the resident and the fees to be paid. The inspector noted from a sample of contracts reviewed that they did refer to the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms, as required by regulation. There were a number of blank sections in this part of the residents' contract that were required to be completed by staff. However, some of these blank sections of the residents' contracts had not been completed and were left blank.

A Residents' Guide was also 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 and a copy was made available to residents and their representatives. There was also a copy of the residents' guide available near the main entrance to the centre.

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 had worked in the centre since 2014 and had been person in charge since January 2016. The person in charge possessed the clinical knowledge to ensure suitable and safe care. During the two days of the inspection, the person in charge demonstrated good knowledge of the legislation and of his statutory responsibilities. He was clear in his role and responsibilities as person in charge and displayed a strong commitment towards providing a person centered high quality service. For example, he outlined how since his appointment that he had promoted continuous improvement in residents' care by the establishment of a number of quality initiatives in areas such as falls prevention, end of life care and nutrition and hydration. He also demonstrated a strong commitment to improving the standards of care in the centre as evidenced by the findings from this inspection and by his responsiveness to any identified issues. The person in charge was supported in his role on a daily basis by both the GM and a senior staff nurse who were both PPIM's. The senior staff nurse held the lead in a number of areas including palliative care and infection control.

The person in charge stated that he had a specific interest in providing resident focused person centred care. He outlined how he had researched other designated centres to establish best practices that he could transfer into this centre. For example, he had implemented a new reporting structure for health care assistants to provide care provision records on a daily basis. The aim of this was to enhance the care and support documentation that would ultimately improve residents' care outcomes. He was fully engaged in the governance and administration of the centre on a consistent basis. For example, he regularly met all residents and their representatives, the members of the management team, the activities coordinator, the care staff and nursing staff. Comprehensive minutes were maintained of these meetings.

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:
Residents' records were reviewed by the inspector who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to the inspector.

The inspector reviewed the centre's operating policies and procedures and noted that the centre had site specific policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. These policies were reviewed and updated at intervals not exceeding three years as required by Regulation 4. The centre-specific policies reflected the care given in the centre and informed staff with regard to up-to-date evidenced best practice or guidelines. There was evidence that there was on-going training to staff on policies and procedures and staff had signed off on these once they had received the training.

The inspector viewed the insurance policy dated June 2017 and saw that the centre was adequately insured against accidents or injury to residents, staff and visitors.

The inspector spoke to the GM who managed the human resources and recruitment of staff. The inspector reviewed a sample of staff files and found that they contained all of the information required under Schedule 2 of the Regulations.

The inspector was satisfied that the records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Overall records were seen to be maintained and stored in line with best practice and legislative requirements.

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 was suitable policy's and procedures in place to guide staff in the care and protection of residents. For example there was a policy on safeguarding and elder abuse that had most recently been reviewed in November 2016, a policy on behavior management dated as reviewed in July 2017 and a policy on the use of restraints that was dated as reviewed in August 2017. In addition. the inspector noted that a copy of the national safeguarding policy 2014 was available in the center. The inspector found that there were measures in place to protect residents from suffering harm or abuse. For example, safeguarding training was provided on an on-going basis in-house. From a review of the staff training records all staff had received up-to-date training in a programme specific to protection of older persons. This training was supported by the aforementioned 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. 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 centre maintained day to day expenses for a small number of residents and the inspector saw evidence that adequate financial records were maintained. The inspector reviewed the system in place to safeguard residents' finances and valuables which included a review of a sample of records of monies and valuables handed in for safekeeping. A small amount of money and valuables were kept in a locked area in the centre. All lodgements and withdrawals were documented and were signed for by staff members. In relation to the storage of valuables the inspector noted that suitable records were maintained including photographs of residents' jewellery. The provider representative confirmed that the centre did not act as a pension agent for any residents.

There was a policy on responsive behaviour (a term used to describe how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). This policy had most recently been reviewed in July 2017. Staff were provided with training in responsive behaviors along with dementia specific training which was on-going. The inspector noted that there were a number of residents with a diagnosis of dementia living in the center. The person in charge had completed a dementia care audit in August 2017. The inspector reviewed the action plan following this audit. He noted that it included improved individualized and tailored activities, enhanced orientation such as color contrasting toilet seats and door surrounds and a rummaging box. There was also plans for themed reminiscence and doll therapy that were due to be commenced in October 2017. Training records showed that all staff had received up-to-date training in this area at the time of the inspection. There was evidence that for the residents who presented with responsive behaviour they were reviewed by their General Practitioner (GP) or other professionals for full review and follow up as required. Care plans reviewed by the inspector for residents exhibiting responsive behaviour were seen to include positive behavioural strategies. These were clearly outlined in residents' care plans and therefore ensured continuity of approach by all staff using person-centred de-escalation methods.

There was a center specific policy on restraint and there was evidence that the use of restraint was generally in line with national policy. The restraint register recorded eight residents using bedrails and three residents had lap belts on the days of inspection. For

all residents with any form of restraint; there was evidence that there was regular checking/monitoring of residents, discussion with the resident's and/or their family and the GP. The inspector saw that there was an assessment in place for the use of restraint. These clearly identified what alternatives had been tried to ensure that the particular form of restraint was the least restrictive method to use. There were records available for all residents in relation to the trailing of alternatives. The inspector was assured by the practices in place and saw that whenever possible alternative measures were used. For example, there were low-low beds and alarm mats used for a number of residents to reduce the use of bed rails in the centre. The inspector noted there had been a continued reduction in bed rail usage since the last inspection. However, the risk assessment used prior to the application of restraint was not adequate as it did not quantify the actual level of risk that such restraint may present.

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

Findings:
There was a center specific safety statement that was dated as most recently reviewed in August 2017. The GM in conjunction with the person in charge had the lead for ensuring health and safety issues were suitably managed in the centre. The inspector was informed that both met regularly to review all incidents and accidents. This meeting also reviewed procedures and practices including risk management and fire safety in the center. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. All accidents and incidents were recorded on incident forms, were submitted to the person in charge and GM. The inspector noted that there was evidence of suitable actions in response to individual incidents. For example, from a sample of records of incidents involving residents it was clearly recorded the action taken to support the resident following any untoward event. There was recorded information/communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning/changes required to prevent reoccurrence. The provider representative received regular updates in relation to any incidence/accidents. For example, he was appraised about any falls, pressures sores, wounds, level of restraint and any significant events occurring. The regular management meetings met to also review any accidents, incidences or near misses and manage the risks and hazards in the centre. There were examples seen by the inspector of suitable responsive actions taken following such incidents/accidents.

Such action included for example, reviews of practice, care planning, updated risk assessments and further staff training.

There were adequate governance and supervision systems in place to monitor residents at risk of falls, wandering or negative interactions. These were reviewed by the GM and the person in charge on an ongoing basis. Overall the premises appeared safe and there were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors and safe walkways were seen in the outside areas. The inspector noted that residents had unrestricted access to three outside areas. However, the inspector noted that this arrangement had not been risk assessed.

The person in charge was identified as the fire safety manager and the GM as the deputy fire safety manager. The fire policies and procedures were centre-specific and the fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. Staff demonstrated appropriate knowledge and understanding of what to do in the event of fire. The inspector saw that fire training was regularly provided to staff with the most recent training recorded as occurring in May 2017. All staff had up to date fire training as required by legislation. The inspector examined the fire safety register which detailed services and fire safety tests carried out. All fire door exits were unobstructed and fire fighting and safety equipment had been most recently tested in July 2017. In addition, there were records of weekly fire alarm and emergency lighting and daily monitoring of fire exits. There were two residents that smoked tobacco in the centre at the time of inspection. There was a smoking room available for residents' use which contained a fire extinguisher, call bell facility or fire blanket within reasonable proximity to this room in the event of a resident requiring assistance. Residents who were smokers had individual smoking risk assessments in place and all cigarettes and lighters were safely stored by staff. However, these smoking risk assessments required review as they did not quantify the actual level of residual risk associated with the resident smoking and therefore it was unclear as to what level of controls were required to mitigate against such identified risks.

The person in charge told the inspector and records and staff confirmed that fire drills were undertaken regularly both day and night time. The inspector noted that the number of participants, the actions taken and outcome of the fire drills were documented. However, the records of the fire drills needed improvement for example, these records did not record the length of time for each drill to be completed or any difficulties, learning or improvements required following these practice drills.

Detailed personal emergency evacuation plans (PEEPS) were seen to be completed for residents. These records outlined the assistance that residents required in an emergency fire evacuation situation. The PEEP records viewed were not adequate as they did not contain adequate details regarding the residents' level of supervision when brought to a place of safety following evacuation. However, inspector noted that the PEEP records had been amended to include this additional information before the completion of the inspection.

The fire safety policy was centre specific and had been reviewed most recently in October 2016. The emergency lighting was checked regularly as part of the overall fire

safety monitoring by staff in the centre. The inspector noted that the emergency lighting was serviced quarterly by a competent person and most recently in July 2017. The fire alarm system was also inspected quarterly each year. The inspector noted from the most recent fire alarm service report that there were a number of recommendations contained in this report in relation to enhancing the fire safety arrangements. For example, the report recommended changes some of the heat detectors to be replaced by smoke detectors in some rooms and the provision of additional smoke detectors in other areas. The inspector noted that these recommendations had not been actioned. However, when this issue was brought to the attention of the provider he immediately contacted his fire safety engineer who was on site to remedied this issue by the evening of the first day of inspection.

Overall there were systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. The communal areas and bedrooms were found to be clean and there was good standard of general hygiene in the centre. Staff that were interviewed demonstrated good knowledge of the correct cleaning procedures to be followed. All hand-washing facilities had liquid soap and paper towels available. There were centre specific policies and procedures in place on infection prevention and control. All staff interviewed were adequately knowledgeable in infection prevention and control or demonstrated suitable hand hygiene practices. Documentation seen indicated that hoists required for moving techniques in resident care were serviced regularly. Care plans contained a current manual handling assessment and plan that referenced the specific equipment required for resident and staff safety. Manual handling practices observed were seen to be in line with current best practice and the training matrix recorded that all staff were trained in manual handling. However, the inspector was informed that the slings to be used with lifting hoists were shared and not individualized. This arrangement was not adequate to ensure best practice in infection control and the prevention of cross contamination.

The health and safety policy was recorded as being most recently reviewed in February 2016. There was a risk management policy as set out in schedule 5 of the regulations and was dated as reviewed most recently in August 2016. This policy included all 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. In addition, the risk management policy included the measures and actions in place to control specified risks as required by regulation. There was a risk register available in the centre which covered for example, risks such as residents' falls, fire safety risks and manual handing risks. However, the hazard identification process required review to include the unrestricted access to staff changing room.

Judgment:
Non Compliant - Moderate

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

Theme:

Safe care and support

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

Findings:
There was a centre specific medication policy which was dated as reviewed most recently in July 2017. Medication management training had been provided to all nursing staff. There were records of medication competence assessments having been completed by nursing staff throughout 2017. There was a community retail pharmacist who supplied medication and supported the centre by providing a pharmacist who visited the centre each month. The pharmacist provided support and medication reviews with the most recent recorded on 4 September 2017. Inspectors noted that the most recent review was recorded as being completed in September and the inspector noted a high level of compliance had been achieved.

Nursing staff with whom inspectors spoke demonstrated adequate knowledge of the general principles and responsibilities of medication management. Medication administration practice was observed by the inspector. Nurses wore red "do not disturb bibs" while administrating medications and the inspector noted that the nursing staff adopted a person-centred approach. For example, when administrating medication staff were observed interacting with each resident in a supportive and consider manner; speaking to residents and eliciting feedback prior to administering medication. Medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. The temperature of the medication refrigerator was noted to be within an acceptable range and the temperature was monitored and recorded daily.

Compliance aids were used by nursing staff to administer medicines. A sample of medication prescription records was reviewed. The practice of transcription was in line with the centre-specific policy and guidance issued by An Bord Altranais agus Cnáimhseachais for all prescriptions seen. However, from a sample of medication administration records examined, the inspector noted that there were a number of improvements required including the following:
• there were some prescriptions that had been amended using free hand which were unclear
• there was erasing fluid used on one prescription record seen
• there were a number of ways that the tick box's on the prescription record that had been completed or amended using a number of different formats therefore potentially allowing a misunderstanding/medication error to occur.

There were measures in place for the handling and storage of controlled drugs that were accordance with current guidelines and legislation. Nursing staff with whom the inspector spoke demonstrated knowledge of the general principles and responsibilities of medication management. Controlled drugs were recorded as administered in the medication administration records in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais.

Judgment:
Non Compliant - Moderate

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:
The inspector saw that there was a comprehensive log of all accidents and incidents that took place in the centre. Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 had been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents and incidents as required.

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):
No actions were required from the previous inspection.

Findings:
The inspector noted that care was provided in accordance with the center's statement of purpose dated as reviewed in September 2017. Nursing care was provided to residents in a safe, homely and comfortable environment. The person in charge outlined how all prospective residents were assessed by a member of the nursing management team. This pre admission assessment was carried out to ensure that each resident met the admission criteria as stated in the centers' statement of purpose. The inspector noted

that the centre catered for low to maximum dependency residents including residents with dementia, disabilities and provided long term care, convalescent and palliative care. Following the assessment the planned admission was communicated in detail to the nursing staff to arrange transfer/admission. The inspector noted that on the days of inspection there were 15 residents assessed as having maximum dependency, 18 residents assessed as having high dependency needs, 15 residents as having medium care needs and five residents as having low dependency care needs.

The inspector was satisfied that residents' healthcare requirements were met to a good standard. There was a morning and evening handover each day and all staff including the person in charge discussed residents clinical, health and social care needs. This meeting was also used to highlight to all staff any changes or issues of concern. Residents to whom the inspector spoke to confirmed that they were well cared for and were very complementary about the kindness and standard of care and support provided to them by all staff.

From a review of documentation; there was evidence to support that residents' healthcare requirements were adequately and regularly assessed by competent nursing staff. That arrangements were in place to meet their assessed clinical needs. On admission, residents were facilitated to retain access to their general practitioner (GP) of preference and there were 14 different GP's attending the center at the time of this inspection. There was evidence that residents, as appropriate to their needs, had access to other healthcare professionals and services including dietetics, speech and language therapy, occupational therapy, psychiatry, chiropody and physiotherapy. There were also records of arrangements in place to facilitate optical and dental review. There were records of residents receiving the seasonal influenza vaccination.

The inspector saw that each resident had a nursing plan of care. Nursing staff informed the inspector that there had been significant changes made to the care planning documentation/record system since the previous inspection. Nursing staff used a key-nurse system for care plan completion and health care assistance also completed a care provision record each day. The inspector reviewed a random sample of care plans and was satisfied that the system was clearly understood by staff and the general standard of care planning was good. There was evidence that each care plan was informed by assessment and reassessment as required and at a minimum four monthly intervals. Care plans were completed in consultation with the resident and/or their representative and were supported by a number of validated assessment tools. Care plans seen were person centred, clearly set out the arrangements to meet identified needs as specific to each resident. They also incorporated interventions prescribed by other healthcare professionals for example speech and language therapist or dietetics. A daily nursing record of each resident's health, condition and treatment given was maintained and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations.

There was a low reported incidence of wounds. The inspector saw that the risk of wound development was regularly assessed by nursing staff and the person in charge provided oversight by regularly auditing these plans. Preventative strategies including pressure relieving equipment were implemented. A validated assessment tool was used to establish each resident's risk of falling and there was evidence of the routine

implementation of falls and injury prevention strategies including close monitoring or residents and low beds. The resident's right to refuse treatment was respected and recorded and brought to the attention of the relevant GP. There were procedures in place and records seen supported that relevant information about the resident was provided and received when they were absent or returned to the centre from another care setting.

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

Findings:
The centre was located in the town land of Rathkeevan which was a rural setting eight kilometers from the town of Clonmel. The premises was purpose built in 2001 and was a single story building. The inspector was satisfied that the location, design and layout of the centre was suitable for its stated purpose. That it met residents' individual and collective needs in a comfortable and generally homely way. The premises was laid out in four parallel and interconnected blocks. The main entrance was wheelchair accessible and lead into a spacious lobby from which the main reception area was accessed. The main reception area contained the nurses' station, a designated smoking room, an oratory, a visitors' room and one of the three available communal sitting rooms. The remaining two communal rooms were located in each of the three interconnecting corridors. There were two dining rooms provided; one large central dining room adjacent to the kitchen and a smaller dining room; both overlooking the enclosed garden areas. Resident accommodation was provided in 47 single bedrooms and seven twin rooms. All bedrooms had an en suite toilet, wash-hand basin and assisted shower. The size and layout of bedrooms was suited to meeting the needs of residents including those with high dependency needs.

There was adequate space and storage facilities provided to residents for personal possession including lockable storage in each bedroom. However, the inspector noted that a number of residents' bedrooms doors could not be secured by residents if they wished. In addition, one anonymous complaint put into the centers' suggestion box which stated that some staff did not always knock on bedroom doors prior to entering

residents' bedrooms. The provider representative informed the inspector that this issue had been identified and part of the response to this complaint was that new locks would be fitted to all remaining bedroom doors. The provider representative stated that these locks had been ordered and would be installed within the next two weeks. This issue was also identified under outcome 13 of this report.

There were a further two toilets, and an assisted bathroom with toilet, wash-hand basin and
communal bath available. A treatment room, hairdressing room, sluice room, administration office, laundry, kitchen and ancillary areas, two cleaners stores and staff changing facilities. However, the unrestricted access to staff changing facilities had not been risk assessed and this issue was action under outcome 8 of this report.

The premises was located on a spacious rural site that provided for a landscaped area with walkways and three enclosed patio areas, one off each of the interconnecting corridors. In each of these enclosed gardens there were a number of shrubs and raised flower beds and some garden furniture. However, the inspector noted that in one of the patio areas there was inadequate furniture provided with one garden chair available for residents use.

The premises to be visibly clean, well maintained, adequately heated, lighted and ventilated and in generally in good decorative order. However, there were some areas that required repainting for example some of the corridor walls and doors seemed marked/scratched.

There was suitable provision made for the safe storage of equipment; chemicals and cleaning products
were securely stored in locked cleaning cupboards. The necessary sluicing facilities were provided
and access to most high risk areas such as the sluice room and the laundry was restricted. The laundry room was adequate and there was a designated wash hand basing provided.

Circulation areas, toilet facilities and shower/bathrooms were adequately equipped with hand-rails and grabrails. Emergency call facilities were in place that were accessible from each resident's bed and in each room used by residents. A separate kitchen was provided and was located off the main dining room. The inspector observed the kitchen to be visibly clean and well-organised. There was suitable and sufficient cooking facilities, kitchen equipment and tableware. Staff were provided with dining, changing, storage, showering and sanitary facilities.

Judgment:
Substantially Compliant

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 were center specific policies and procedures which complied with legislative requirements in place for the management of complaints and the complaints policy was reviewed in June 2017. There was an independent appeals process and complaints could be made to any member of staff. The person in charge was the designated complaints officer. There was a named second person as required by regulation in relation to the monitoring and management of complaints. Residents were aware of the complaints' process which was on public display.

The inspector noted that there were no open complaints on the days of inspection. There were a small number of complaints recorded for 2017 and on review of the complaints log there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcome of their complaint and records evidenced whether or not they were satisfied. All complaints were reported as part of the regular management meetings and to the provider representative. Complaints were reviewed regularly by the person in charge and as part of a recent audit programme. There was evidence of on-going review of complaints by the GM and the person in charge to identify any learning or changes that were required. For example, as already identified in outcome 12 of this report, the issue in relation to one anonymous complaint that had been put into the centers' suggestion box stated that some staff did not always knock on bedroom doors prior to entering the bedroom. The inspector noted that the person in charge had taken a number of actions in response to this complaint including the following. He had met staff and informed them of the contents of this complaint and reminded staff of the centers' policy and procedures for ensuring residents privacy and dignity at all times. The person in charge had also reassured residents through the residents committee meetings and from regularly meetings with residents and their representatives in relation to this issue. There was clear evidence of such meetings from speaking to residents, visitors and records seen by the inspector. In addition, this issue was discussed with the provider representative who had arranged for new locks to be fitted to all remaining bedroom doors.

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:
The policy on the management of end of life care which was dated as reviewed most recently in July 2017. At the time of inspection there were no residents receiving end of life care. Overall there was evidence of a good standard of medical and clinical care provided. The person in charge outlined that if required appropriate access to specialist palliative care services would be provided. The person in charge also outlined how he had established an end of life action plan group. This group had representation from staff and management including nurses, healthcare assistants, the activities coordinator and the person in charge. There was evidence of good end of life practices including suitable end of life care plans with recorded communications with the resident in relation to their wishes and preferences including their spiritual needs. There was evidence of on-going dialogue with residents' families or their representatives in relation to the residents' end of life needs. The inspector noted that following the death of a resident this end of life action plan group reviewed each residents' care during and after their death. This meeting was held in order to see how the center might improve its' practices. For example, following the death of a resident; the residents family were supported as much as possible including sending them a sympathy card to acknowledge their loss and also a first anniversary memory card. The person in charge also had plans for the implementation of the Irish Hospice Foundation "Think ahead" planning document; which would help residents or their representatives to plan all aspects of their end of life care. The person in charge planned to roll out in the centre over the next number of months.

The inspector found that staff were aware of the policies and processes guiding end of life care. Staff to whom the inspector spoke outlined suitable arrangements for meeting residents' needs, including ensuring their comfort and care. Staff spoken to were able to describe suitable and respectful care practices in relation to end of life care provision. The inspector noted that families were notified in a timely manner of deterioration in residents' condition and were supported and updated regularly as required. There were facilities to support relatives remain with their loved ones during end-of-life including the use of one of the apartments adjacent to the centre to enable families remain overnight, if required.

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:
Residents were provided with food and drink at times and in quantities adequate for their needs. The dining experience was observed during the mid day meal in the dining room adjacent to the kitchen and in one of the day rooms. The inspector noted that assistance was offered to residents in a discreet, patient and sensitive manner by staff. The dining experience was a social occasion and a number of residents were seen chatting with each other throughout their meal. Staff also used meal times as an opportunity to engage in a meaningful way with residents, particularly with residents to whom they gave assistance. The inspector noted that the person in charge and the activities coordinator sat, chatted and enjoyed a cup of tea with residents during their meal. The activities coordinator confirmed that this was part of her role in promoting the social aspect of the dining experience.

Those residents on modified diets were offered the same choices as people receiving normal diets. A three week rolling menu over was in place to offer a variety of meals to residents. The person in charge had implemented a diet matrix for all residents which was a systematic and structured care planning, recording and implementation tool in relation to nutrition. For example, this matrix captured each residents nutritional assessments, likes/dislikes, their preferences in relation to the location for having their meal, any texture requirements or allergies present. The person in charge in consultation with the dietitian and the support of the chef had implemented a programme aimed at reducing the use of artificial food supplements in the center. The approach was to replace whenever possible artificial food supplements with home cooked nutritious food. This was only done under the guidance of the dietitian and as part of the residents' nutrition care plan. The person in charge gave examples of certain food supplements that they had replaced with for example, home made wholesome soup made from locally sourced ingredients. The person in charge stated that this change had been very popular with residents.

The inspector noted that most residents took their meals in the dining room and in one of the day rooms. Tables in both rooms were appropriately set with cutlery condiments and napkins. Residents spoken with agreed that the food provided was always very good and appetising. Overall residents were happy with the food provided in the centre and some residents stated that that "it was like a hotel and that the food was excellent".

The inspector spoke with the chef who outlined how she was knowledgeable about residents dietary needs and preferences. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. A list of all special diets required by residents was compiled on foot of the individual residents' reviews and copies were available in the kitchen.

Drinks such as water, milk, tea and coffee were available. Access to fresh drinking water

was available at all times and jugs of water were observed in residents' rooms. Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition. The inspector looked at this system in place to monitor food intake. The system of recording was found to be consistent/detailed enough to enable meaningful analysis as to the adequacy of intake for at risk residents.

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):
No actions were required from the previous inspection.

Findings:
There was clear evidence that residents and/or the representatives were consulted with and participated in the organisation of the center. For example, there were records of meetings with resident and their families available and such consultation was confirmed by residents and relatives to whom the inspector spoke. Regular meetings residents committee meetings were held with the most recent meeting recoded as having occurred in March 2017. The person in charge outlined that the role of these meetings was to ensure residents' actively participated in decision making. The inspector noted that the residents' committee was facilitated by the activities coordinator and the committee met regularly to also discuss issues such as future activities or outings. Feedback and suggestions were recorded with an action plan and timeframes. The person in charge, the GM and the activities coordinator met every month to review any issues raised at the residents' committee meetings. There was evidence of changes having been made as a result of these meetings. For example, there had been an issue about the response times of some call bells, suggested changes to the menu choices and options for outings from the centre. The inspector noted that all these issues had been actioned appropriately and changes/improvements had been implemented. In addition, the inspector noted that the person in charge had also sought feedback from residents to ensure that they were happy with any such changes.

There were no restrictions to visiting in the center and the inspector observed several visitors at different times throughout the two day inspection. Residents' right to choice,

and control over their daily life, was also 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 rooms. Overall, residents' rights, privacy and dignity were respected, during personal care, when delivered in their own bedroom or in bathrooms. Aside from the previously mentioned anonymous complaint; a number of residents spoken with confirmed that they were afforded choice in relation their daily lives and for example were facilitated to receive visitors in private. One visitor stated that she visited the centre at different times including early morning or late at night. She stated that she was always assured by what she saw and heard from staff in the respectful way that they provided care and support to her relative and other residents.

A programme of varied internal activities and external trips was in place for residents. Information on the day's events and activities was prominently displayed in the centre. The activities coordinator was very visible and actively involved with supporting residents. Residents to whom the inspector spoke with confirmed that the activities coordinator was well known to residents, provided on-going support to them and was very approachable. The inspector spoke to the activities coordinator who outlined how she delivered the programme which included both group and one to one activities. The inspector was told that residents spiritual needs were met through regular prayers in the center's Oratory and Mass celebrated in the St Mary's church in Clonmel. The inspector was also informed that any other religious denominations were catered for as necessary. Outside of religious ceremonies, the Oratory was available as a quiet space for residents to pray and reflect.

Judgment:
Compliant

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:
There was a centre-specific policy on residents' personal property and possessions and from the sample of residents' records reviewed by the inspector. There were records in place of individual resident's clothing and personal items.

Residents laundry was well maintained and most laundry facilities were provided on-site. There were appropriate arrangements in place for the regular laundering of linen and clothing and procedures were in place for the safe return of residents' personal clothing

items. The inspector spoke to the centers' administrator and reviewed the management of residents' finances which included suitable record log and system of double signing for transactions. Residents that the inspector spoke with indicated that they were satisfied with the arrangements in place in relation to the management of residents' personal property. Each resident had a secure storage facility in their bedroom for the safekeeping of any personal items or small quantities of monies.

The provider representative confirmed that the center did not act as a pension agent for any residents.

Residents were facilitated to have their own items, such as assisted equipment or furniture and personal memorabilia. The inspector noted that most bedrooms had been personalized with individual residents' items, photographs and art work. Each resident had suitable furniture in their bedrooms to store clothing and personal items in their own bedside cabinets and wardrobes.

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:
An actual and planned roster was maintained in the centre. The inspector reviewed a sample of staff rosters which showed that the person in charge was on duty Monday to Friday and that he was supported in his role by the GM and staff nurses. There were two nurses were on duty both on day and night times and the inspector spoke to both groups of staff. The centre was divided into two sections with one staff nurse allocated to each. The person in charge had implemented a new daily monitoring record of care provided that was completed by healthcare assistants. This record was in addition to the daily narrative note in relation to the care and welfare and treatment given that was completed by staff nurses in the residents care plans.

The inspector observed practices and conducted interviews with a number of staff. This

staff included the person in charge, the activities coordinator, cleaning and household staff, healthcare assistants, the general manager, the chef and kitchen staff, the administrator, staff nurses on both day and night duty and the provider representative. Staff appeared to be supervised appropriate to their role and responsibilities. This was evidenced by speaking to staff and management including the provider representative and a review of documentation including staff rosters, reporting arrangements and staff files. Records viewed by the inspector confirmed that there was a good level of training provided with numerous training dates scheduled for 2017. Staff told the inspector they were encouraged to undertake training by the person in charge. Mandatory training was on-going and staff had attended a number of trainings with all staff had completed mandatory training in areas such as fire training. Fire evacuation drills were provided by the GM both on day and night times. Mandatory training in manual handling and safeguarding was found to be up to date. Staff also attended training in areas such as the prevention of falls, infection control and medication management.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. The provider representative confirmed that all staff had suitable Garda vetting in place. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector.

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:

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Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Rathkeevan Nursing Home
Centre ID:	OSV-0000271
Date of inspection:	13/09/2017 and 14/09/2017
Date of response:	09/10/2017

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:
To agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the center including the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms, as required by regulation.

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 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
All sections of the Contract of Care requiring to be completed have now been completed including the number of Occupants per room.

Proposed Timescale: 18/09/2017

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:
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 including suitable risk assessment used prior to the application of restraint.

2. 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:
•Restraint will only be used in accordance with National Policy. All Risk assessments used prior to application of restraint have been quantified and will be in the future.

Proposed Timescale: 18/09/2017

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:
To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout
- the designated center including the following:
- the unrestricted access to these outside areas
- the smoking risk assessments for resident who smoked
- the unrestricted access to staff changing room.

3. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The Risk Management Policy will be updated to include identification and assessment of risks regarding:
● the unrestricted access to these outside areas.
● the smoking risk assessments for resident who smoked.
● the unrestricted access to staff changing room.

Control Measures will be put in Place

Proposed Timescale: 27/10/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
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 including the arrangements for the use of communal lifting slings.

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:
Individualized Slings are now provided for residents requiring the use of lifting hoists

Proposed Timescale: 21/09/2017

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:
To ensure that all medicinal products are administered in accordance with the directions of the prescriber and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product including the following:
• there were some prescriptions that had been amended using free hand which were unclear

• there was erasing fluid used on one prescription record seen
• there were a number of ways that the tick box's on the prescription record that had been completed or amended using a number of different formats therefore potentially allowing a misunderstanding/medication error to occur.

5. 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:
•G.P's are being requested to write more clearly and not to use erasing Fluid.
•A single symbol will be used in the future on the prescription record to avoid potential medication errors.

Proposed Timescale: 18/09/2017

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:
To provide adequate private and communal accommodation for residents including the provision of suitable locking facility on residents' bedroom doors.

6. 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:
All bedroom doors will be fitted with suitable locking facilities

Proposed Timescale: 27/10/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the premises is of sound construction and kept in a good state of repair externally and internally.

7. 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:
• Corner protection and door protection plates will be provided to vulnerable areas.
• Painting and Decoration will be maintained on an ongoing basis.

Proposed Timescale: 27/10/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To provide external grounds which are suitable for, and safe for use by, residents and that such grounds are appropriately maintained including the provision of adequate outdoor/garden furniture for residents use.

8. 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:
Outdoor Patio areas will be appropriately maintained.
New Patio Furniture has been procured for each of the 3 patios.

Proposed Timescale: 27/10/2017