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:	St Josephs Nursing Home
Centre ID:	OSV-0005413
Centre address:	Lurgan, Glebe, Virginia, Cavan.
Telephone number:	049 854 7012
Email address:	brid.cahill@stjosephsnh.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	St. Joseph's Nursing Home Limited
Provider Nominee:	Stephanie Dawn McLean
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	4

About Dementia Care Thematic Inspections

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

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

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
26 April 2017 09:45	26 April 2017 18:00
27 April 2017 09:30	27 April 2017 13:15

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs		Non Compliant - Moderate
Outcome 02: Safeguarding and Safety		Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation		Compliant
Outcome 04: Complaints procedures		Compliant
Outcome 05: Suitable Staffing		Compliant
Outcome 06: Safe and Suitable Premises		Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Substantially Compliant
Outcome 08: Governance and Management		Substantially Compliant
Outcome 09: Statement of Purpose		Compliant
Outcome 10: Suitable Person in Charge		Compliant

Summary of findings from this inspection

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

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

The inspector met with residents, staff members and the centre's management team. The inspector tracked the journey of residents with dementia and observed care practices and interactions between staff and residents. A formal recording tool was used for this purpose. Documentation to include care plans, medical records and staff files were examined.

There were 48 residents in the centre during the inspection. The majority of residents are accommodated for long term care. There were 35 residents with high dependency care needs. Eleven residents were assessed as medium dependency and two had low dependency care needs. At the time of inspection 32 residents were identified with a dementia related condition as their primary or secondary diagnosis. There were no residents under 65 years of age accommodated in the centre with a dementia related condition at the time of this inspection

HIQA received a notification of a change of person in charge in April 2017. The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience.

There are two nurses rostered each day of the week and the person in charge works full time five days each week. There are two clinical nurse manager (CNM) roles with a second CNM recently appointed who will work an opposite shifts to support nursing staff. There was a regular pattern of rostered care staff. There are seven care staff rostered throughout the morning until 2.00pm and six until 8.00pm.

Residents with dementia were seen to receive care in a dignified way that respected their personhood. The inspector observed staff interactions with residents that were appropriate and respectful in manner. The centre had a dedicated full-time activities coordinator role who manages a programme of activities and also organised special events and celebrations.

The general practitioner (GP) visited the centre routinely. Residents had regular access to the services of allied healthcare professionals or as required; these included a speech and language therapist, dietician, optician and chiropodist. There is a physiotherapist employed by the provider two days per week.

The inspector reviewed a sample of resident care plans. Care plans were developed for issues identified on assessment. However, there was a variation in the standard of care planning. Risk assessments were not reviewed in all cases at required four monthly intervals. Other aspects identified for improvement include the requirement for refresher fire safety training and further work to promote a restraint free environment.

A total of ten outcomes were inspected. The inspector judged five outcomes as compliant and four as substantially complaint. One Outcome, Health and Social Care Needs was judged moderate non-compliant. The Action Plan at the end of this report identifies a small number of areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
There were 48 residents in the centre during the inspection. The majority of residents are accommodated for long term care. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition. There were 35 residents with high dependency care needs. Eleven residents were assessed as medium dependent and two had low dependency care needs.

Residents could retain the services of their own general practitioner (GP) and had regular access to the services of allied healthcare professionals or as required; these included a speech and language therapist, dietician, optician and chiropodist. There is a physiotherapist employed by the provider two days per week. The physiotherapist is available to review all residents and undertake individual exercises to promote mobility and improve respiratory function.

The inspector tracked a sample of resident care plans. A preadmission assessment was completed to ensure the centre could meet the needs of a prospective resident. On admission a range of risk assessments were completed and were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, nutritional care, the risk of developing pressure sores, continence needs and cognitive functioning.

Care plans were developed for issues identified on assessment. There was a variation in the standard of care planning. Risk assessments were not reviewed in all cases at required four monthly intervals. Further detail is required within care plans for residents with dementia or impaired cognition to detail the level of confusion or cognitive impairment and how it impacts on daily life for the resident. Information such as who the resident still recognises or what activities could still is undertaken.

Some care plans for responsive behaviours did not always detail clearly the full extent of some of the issues being managed for residents with complex mental health problems. The detail of potential triggers and deescalating techniques require review to provide more detail to guide staff interventions. There was documentary evidence of

consultation with residents or their representative in all care plans of regular contact to inform a resident's next of kin of any changes in the planned care pathway or health status.

Residents either diagnosed with dementia or presenting impaired cognition had appropriate assessments around communication needs in place. The residents' nutritional needs were well met. Residents were seen to be provided with a regular choice of freshly prepared food. Menu options were available and residents on a modified diet had the same choice of meals as other residents with appropriate consideration given to the presentation of these meals. There was good use of brightly coloured plate's cups in the dining room.

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

There were written policies and procedures in place for end-of-life care and for the management of residents' resuscitation status. Staff provided end of life care to residents with the support of their GP and the community palliative care team. There was one resident under the care of the palliative team. While records indicated that end-of-life preferences were discussed with residents and/or their relatives again there was variation in the standard of care planning. End- of- life care plans were not updated in all cases to reflect a residents' resuscitation status.

There was one resident with a grade 3 pressure wound at the time of this inspection. A wound assessment chart was completed each time dressings were changed. Nursing notes did not outline a clinical evaluation of the progress of the wound. Notes stated 'dressing changed and cleaned'. There was no evidenced based reporting as to the progress of the adequacy of the type and frequency of the care interventions, dressings applied and assessment of pain. The care plan was not updated from the time it was commenced six months previously. The interventions outlined were not specific to guide the current required interventions to manage the wound.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
A policy was in place for the protection of vulnerable adult's which included guidance on protected disclosures. Records indicated that regular training on safeguarding vulnerable adults was provided. Staff members spoken to had received training and understood how to recognise instances of abusive situations and were aware of the appropriate reporting systems in place.

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

There were policies in place to guide staff on meeting the needs of residents with responsive behaviour and restrictive practices. Policies gave instruction to guide staff practice. Training records reviewed by the inspector indicated that staff were facilitated to attend training related to the care of older people with dementia. This included components on how to manage responsive behaviours. The operations manager has completed a training program led by the psychiatry team and the Health Service Executive (HSE) titled, Functional Interventional Training System (FITS). The operations manager has developed an onsite training program which will be delivered to all staff during 2017 to ensure staff have the skills and competencies appropriate to their role to respond and manage responsive behaviour.

Restraint management procedures were in line with national policy guidelines (the use of bedrails). Work to promote a restraint free environment was in progress. At the time of this inspection there were 30 residents with two bedrails raised, 19 as an enabler and 11 assessed as a restraint measure. A risk assessment was completed prior to using bedrails. Signed consent was obtained. The documentation did not outline or describe well how the raised bedrail supported the resident and ensured an enabling function when bedrails were requested by residents. Further work in the trialling of alternatives to include beds being placed at the lowest level and providing sensor mats is required.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
There were no restrictive visiting arrangements apart from mealtimes. Visitors were variously present throughout the day. Those spoken with by the inspector confirmed their satisfaction with the care and services provided. Relative were highly complimentary of individual attention given by staff to personal hygiene and grooming for their relative and the choice and quality of the menu options. There were areas for residents to receive visitors in private should they so wish.

The centre had a dedicated full-time activities coordinator role who manages a programme of activities and also organised special events and celebrations. Birthdays are celebrated with the resident's permission. Live music session are planned routinely. There were also one-to-one activities for residents that do not participate in group activities. The activities coordinator spoke to the inspector at length and described the variety of interactions to ensure residents have suitable physical and mental stimulation suitable to their capacity and life stage.

Aside from routine observations by the inspector, as part of the overall inspection, a standardised tool was also used to monitor the extent and quality of interactions between staff and residents. The inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in the communal sitting room. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care).

Three episodes were monitored in this way both during the morning and afternoon. Each observation episode returned a positive result with notes that staff had engaged positively and meaningfully with residents on a regular basis. Residents with dementia were seen to receive care in a dignified way that respected their personhood. The inspector observed staff interactions with residents that were appropriate and respectful in manner. The inspector found 100% of the three observation periods (total observation period of 30 minutes respectively) the quality of interaction score was +2 (positive connective care).

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

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

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

Residents were familiar with staff. At meal times staff were seen to be speaking to residents, and where support to eat and drink was being provided, it was done in a

discreet way. Where residents were able to eat themselves they were supported to do so, for example, some residents had coloured cups and plates.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

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

A complaint file was maintained that had the facility to record each complaint with details of any investigation into the complaint and whether or not the complainant was satisfied with the outcome. Staff members spoken with could explain how complaints were reported and logged and also how learning from complaints was communicated.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
There was an adequate complement of staff with the proper skills and experience on each work shift to meet the assessed needs of residents at the time of this inspection, taking account of the purpose and size of the designated centre.

There are two nurses rostered each day of the week and the person in charge works full

time five days each week. There are two clinical nurse manager (CNM) roles with a second CNM recently appointed. The management team indicated the CNM's will be rostered on opposite shifts and will have a day allocated each week for governance and administration duties. On the other days they will work in the delivery of clinical care alongside the rostered nurse. There a two nurses rostered for night duty. This is an increase since the last inspection.

There was a regular pattern of rostered care staff. There are seven care staff rostered throughout the morning until 2.00pm and six until 8.00pm. There are two care assistants rostered from 9.30pm with two nurses until 8.00am.The staffing complement additionally includes the activities coordinator, catering, housekeeping, administration and maintenance staff. The centre does not use agency staff.

There was a varied programme of training for staff. Records viewed confirmed there was an ongoing program of mandatory training in areas such as safeguarding vulnerable adults, fire safety evacuation and safe moving and handling. Staff also had access to a range of education, including planned training in dementia and responsive behaviours that explained the condition, the progression of the disease and effective communication strategies. The majority of staff had completed training on infection control during 2016. The management team have plans to deliver training on end-of-life care for all staff during 2017

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. Recently recruited staff confirmed to the inspector they undertook an interview and were requested to submit names of referees. Staff files contained all matters required by Schedule 2 of the regulations.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The centre is situated on a large, well maintained site. The building is adapted to meet the needs of dependent older people and is comfortable and welcoming. All parts of the building were comfortably warm, well lit and ventilated. Access to the centre and service areas is secured in the interest of safety to residents and visitors.

Bedroom accommodation comprises 24 single rooms and 14 twin rooms. Bedrooms

were personalised. It was observed that there was adequate room in the bedrooms for furniture including a bed, a chair and storage. There was a call bell system in place at each resident's bed. Suitable lighting was provided and switches were within residents reach. There were a sufficient number of toilets, baths and showers provided for use by residents. Toilets were located close to day rooms for residents' convenience. One of these bathrooms was upgraded since the last inspection and is more spacious and accessible.

There were visual cues and pictorial signage to guide residents. Each bedroom door had a representation of a front door in different colours with a letter box and door knocker. There was signage at intervals to direct residents to bedrooms and pictorial signage to identify bathrooms along the corridor. However, there were no signs on en-suite bathroom doors to identify the bathroom facilitates. There were clocks in bedrooms to help orientate residents' regards time.

The provider discussed plans to enhance the physical aspects of the building in the immediate future to provide more space in the communal areas. A second larger lift is included in the plans.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

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

Findings:
There were arrangements in place to review accidents and incidents within the centre. Residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, a falls diary was maintained and a post assessment falls tool was developed as required by the action plan of the previous inspection.

The training records showed that staff had up to date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents' needs. Moving and handling risk assessments were completed for each resident and available at the point of care delivery in bedroom for staff to reference.

Hand testing indicated the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to all bedroom windows.

The building, bedrooms and bathrooms were visually clean. There was a colour coded

cleaning system to minimise the risk of cross contamination. A sufficient number of cleaning staff were rostered each day of the week. Hand gels were in place along the corridors and hand-wash facilities were easily accessible. Notices on the five moments of hand hygiene at the point of care and correct hand washing techniques were displayed around the building and in bathrooms.

There were arrangements in place for appropriate maintenance of fire safety systems such as the fire detection and alarm system. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed. Escape route plans were display on each bedroom door. There were procedures to undertake and record internal fire safety checks. Regular checks of the fire extinguishers were undertaken to ensure they were in place and intact, the fire panel and automatic door closers were operational.

Each resident had a personal emergency evacuation plan developed. A risk assessment to identify the most appropriate aids suitable to residents capability to assist them safely evacuate in a timely manner both during the day and at night was in place. Not all staff had refresher training in fire safety procedures within the past 12 months.

The frequency of fire drill practices to reinforce knowledge from annual training require review to ensure all staff have an opportunity to partake in regular drills to reinforce their knowledge from annual training. Only two fire drills were completed since the last inspection.

Judgment:
Substantially Compliant

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
The provider has ensured sufficient resources are in place to ensure that care delivered is in accordance with the statement of purpose. There was a defined management structure in place with which staff were familiar. The governance arrangements in place are suitable to ensure the service provided is safe, appropriate and consistent. The previous person in charge continues to work in the centre on a part time basis as part of the management team to support the role of the newly appointed person in charge. The operations manager attends the centre on a part time basis and reports to the provider.

The provider was onsite at the time of this inspection and met with the inspector. He

discussed his plans to enhance the physical aspects of the building. Planning permission has been obtained. Work is planned to commence on a phased basis to minimise any impact on the daily life of residents.

There was evidence of monitoring of the services. However, the procedures to complete audits require further development to inform learning and ensure enhanced outcomes for residents. This was discussed with the operations manager. The inspector was informed an electronic care planning system is being implemented which will assist in collating data to monitor trends and help develop pro active improvement plans. While clinical data was collated it was not well presented to allow monitoring for trends.

An annual report on the quality and safety of care was compiled for 2016.

Judgment:
Substantially Compliant

Outcome 09: Statement of Purpose

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 set out the services and facilities provided in the designated centre and contained all the requirements of schedule 1 of the regulations.

The statement of purpose was kept up to date and revised to reflect the changes in the management team with the appointment of a new person in charge.

Judgment:
Compliant

Outcome 10: Suitable Person in Charge

Theme:
Governance, Leadership and Management

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

Findings:

HIQA received a notification of a change of person in charge in April 2017. The person in charge is a registered nurse and is noted on the roster as working in the post full-time.

The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. The nominated person to fulfil the role of the person in charge has more than three years experience of nursing older persons within the last six years as required by the regulations. Their mandatory training required by the regulations was maintained up to date.

She is supported in her role by an operations manager who reports directly to the provider.

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:

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

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	St Josephs Nursing Home
Centre ID:	OSV-0005413
Date of inspection:	26 and 27 April 2017
Date of response:	31 May 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 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans for responsive behaviours did not always detail clearly the full extent of some of the issues being managed. The detail of potential triggers and deescalating techniques require review to provide more detail to guide staff interventions.
End- of- life care plans were not updated in all cases to reflect a residents' resuscitation status.

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

1. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
We are reviewing the care plans at present putting extra consideration on potential triggers and deescalating techniques to guide staff interventions. End of life care plans will all be updated.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Nursing notes did not outline a clinical evaluation of the progress of the wound. The care plan was not updated from the time it was commenced six months previously. The interventions outlined were not specific to guide the current required interventions to manage the wound.

2. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
A dietician has reviewed this resident and given recommendations. A tissue viability nurse is also coming to access this resident. All this will be recorded in the residents care plan.

Proposed Timescale: 30/05/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Risk assessments were not reviewed in all cases at required four monthly intervals.

3. 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:
We promote where reasonably practical a restraint free environment. We will try to

further improve our use of bedrail paperwork and trialling of alternatives.

Proposed Timescale: 30/06/2017

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The assessment documentation did not outline or describe well how the raised bedrail supported the resident and ensured an enabling function when bedrails were requested by residents. Further work in the trialling of alternatives to include beds being placed at the lowest level and providing sensor mats is required.

4. 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:
We are currently reviewing our restraint policy and will incorporate the recommendations made by the inspector.

Proposed Timescale: 31/07/2017

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no signs on en-suite bathroom doors to identify the bathroom facilitates.

5. 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:
Signage has been put on all en-suite doors.

Proposed Timescale: 06/06/2017

Outcome 07: Health and Safety and Risk Management
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Not all staff had refresher training in fire safety procedures within the past 12 months. **6. Action Required:** Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire. **Please state the actions you have taken or are planning to take:** Fire Safety Training has been organised to commence on 18th July 2017 - 25th July 2017 for remaining staff.
Proposed Timescale: 30/07/2017
Theme: Safe care and support **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** The frequency of fire drill practices to reinforce knowledge from annual training require review to ensure all staff have an opportunity to partake in regular drills to reinforce their knowledge from annual training. Only two fire drills were completed since the last inspection. **7. Action Required:** Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire. **Please state the actions you have taken or are planning to take:** Further fire simulations are planned for June and July 2017.
Proposed Timescale: 31/07/2017

Outcome 08: Governance and Management
Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedures to complete audits require further development to inform learning and ensure enhanced outcomes for residents.

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

Please state the actions you have taken or are planning to take:
Until the electronic care planning system is implemented we will endeavour to further develop our auditing system to enhance outcome for the residents.

Proposed Timescale: 29/07/2017