**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

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|---|---|
| **Centre name:** | Caiseal Geal Teach Altranais |
| **Centre ID:** | OSV-0005491 |
| **Centre address:** | School Road,<br>Castlegar,<br>Galway. |
| **Telephone number:** | 091 757 609 |
| **Email address:** | adm@cgta.ie |
| **Type of centre:** | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| **Registered provider:** | Caiseal Gael Teoranta |
| **Lead inspector:** | Catherine Sweeney |
| **Support inspector(s):** | Geraldine Jolley |
| **Type of inspection** | Announced Dementia Care Thematic Inspections |
| **Number of residents on the date of inspection:** | 39 |
| **Number of vacancies on the date of inspection:** | 3 |

## 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 06 June 2019 08:30 | 06 June 2019 19:00 |

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 | Substantially Compliant | Non-Compliant - Moderate |
| Outcome 02: Safeguarding and Safety | Substantially Compliant | Compliant |
| Outcome 03: Residents' Rights, Dignity and Consultation | Substantially Compliant | Substantially Compliant |
| Outcome 04: Complaints procedures | Substantially Compliant | Substantially Compliant |
| Outcome 05: Suitable Staffing | Substantially Compliant | Non-Compliant - Moderate |
| Outcome 06: Safe and Suitable Premises | Substantially Compliant | Compliant |
| Outcome 07: Health and Safety and Risk Management | Not applicable | Substantially Compliant |
| Outcome 08: Governance and Management | Not applicable | Non-Compliant - Moderate |
| Outcome 09: Statement of Purpose | Not applicable | Non-Compliant - Moderate |

**Summary of findings from this inspection**

This announced dementia thematic inspection focused on the care and welfare of residents who had dementia. The inspection was carried out to assess compliance with regulations and standards as part of the process of renewing the registration of the centre, which is due to expire on 3 November 2019. The provider had completed a self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older

People in Ireland (2016).

As part of the inspection, inspectors met with the registered provider, the person in charge, the clinical nurse manager, residents, relatives, and other staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The centre is a purpose built facility consisting of 34 single room and 4 double rooms. Most of the living areas within the centre were spacious and well decorated.There was a well-designed enclosed garden with areas that had been developed by residents. Improvements were required on the first floor living areas to make it more appealing for residents to use. There was limited space in the centre for residents to receive visitors in private.

Caiseal Geal Nursing Home is a registered designated centre that provides care for a maximum of 42 residents. Eight residents had a formal diagnosis of dementia .The person in charge informed the inspectors that there were also seven residents in the centre who had symptoms of dementia without having a formal diagnosis. Inspectors tracked the care pathways of residents with dementia and spent periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record the quality of interactions between staff and residents, with specific emphasis focused on residents who had dementia. Documentation such as care plans, clinical records, policies and procedures, and staff records were reviewed.

The inspectors followed up on unsolicited information that had been received by the Office of the Chief Inspector since the last inspection. This information related to staffing levels, supervision and the cleanliness of the centre. The findings from this inspection evidenced that the information received was partially substantiated. Inspectors also followed up on the action plan from the last inspection and found that while some progress had been made Regulation 5 on Individual Assessment and Care Plan required further development to be brought into full regulatory compliance. A full review of the center's Statement of purpose (SOP) was also required in order to meet regulatory requirements.

Inspectors observed many examples of good practice in areas examined which resulted in positive outcomes for residents. Inspectors observed positive staff interactions with residents. Staff were seen to be patient and kind and sought consent in all interactions with the residents. However, Inspectors found that the care received by residents was not reflected in the assessment and care planning documentation.

The centre had appropriate management systems in place. However, a more robust system of audit is required to ensure consistent and effective monitoring of the service provided.

The staffing numbers identified in the SOP did not reflect the staffing that was available to deliver care to the residents. Inspectors found that staffing allocation and levels impacted on the time staff had available to spend with residents.

There was an activities schedule and an activities coordinator to facilitate social engagement within the centre. However, the equal provision of activities to all residents required review.

During this inspection, of the nine outcomes assessed, there were three moderate non compliances, four substantial compliances and two which were compliant. The findings are discussed in the body of the report and improvements are outlined in the action plan.

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

**Findings:**
Inspectors focused on the experience of residents with dementia and tracked their journey prior to and from admission into the centre. Files were reviewed on specific aspects of care, such as falls, nutrition, access to health care and supports, medication management, and management of the symptoms of dementia. There were 39 residents in the centre on the day of inspection. Eight residents had a formal diagnosis of dementia with a further seven residents showing symptoms of cognitive decline.

Residents reported that they felt safe and that they were treated very well. Inspectors were satisfied that the health and social needs of the residents were met, however the care received was not supported by the nursing documentation reviewed. A review of the resident's records found that assessment and care planning processes were not in line with professional guidelines.

The care plans were based on the activities of residents' daily lives. While some care plans outlined personal details about the resident, others were not person-centred and did not guide care. In particular, care plans relating to residents with a diagnosis of dementia did not identify the residents' symptoms of dementia and the interventions required to manage these symptoms.

Inspectors noted that there were no social care plans in place for any residents. Residents with a diagnosis of dementia had a 'planned activity' care plan and a dementia care plan in place. While these care plans were person-centred, they did not detail how staff should respond to the symptoms of dementia displayed by residents. An action plan from the last inspection conveyed a similar finding.

There was a reported high incidence of falls in the centre. The inspectors reviewed the files of residents who had recently fallen and noted that the falls risk assessments and care plans had not been updated prior to or post falls. The person in charge audited falls on a regular basis, but there was no evidence of learning and improvement to practice recorded as a result of the audits. Low-low beds, crash mats, chair and bed sensor

alarms were in use for some residents. The inspectors noted that the communal areas were not supervised by staff at all times. A resident with a recent history of multiple falls did not have a falls risk assessment completed. The residents care plan was not updated to include any fall prevention management plan.

A full range of other services were available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services, tissue viability and psychiatry of later life. Chiropody and optical services were also provided. Eligible residents were supported to avail of the national health screening programme. Inspectors reviewed a sample of residents' records and found that where residents had been referred to these services this was recorded in the residents' notes. However, the residents care plans were not updated to reflect the assessment and care plan from allied health professionals. For example, a resident had been reviewed by a physiotherapist following a fall. The physiotherapist had recommended a plan of care which was not reflected in the residents care plan.

The centre has written policies and procedures in relation to medicines management and inspectors noted that appropriate safe standards were adhered to by nurses.

**Judgment:**
Non-Compliant - Moderate

## *Outcome 02: Safeguarding and Safety*

**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 are policies in place for the prevention, detection and response to abuse of a vulnerable person. Staff had received training and were aware of their roles and responsibilities in relation to safeguarding residents. Residents told inspectors that they felt safe within the centre.

The person in charge confirmed that Garda vetting (police clearance) was in place for all staff and persons who provided services in the centre. Garda vetting was available in the sample of staff files reviewed by the inspectors.

A restraint-free environment was promoted within the centre. The person in charge was in the process of further reducing the number of bed rails used. Interventions such as beds that could be lowered to a low level, sensor mats and crash mats where among the alternatives used to reduce the risk of falling.

There was a robust system in place to manage resident's finances. The centre does not

act as a pension agent for any resident.
All incidents relating to safeguarding of residents have been reported to the Office of the Chief inspector.

**Judgment:**
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:**
Staff were observed to communicate in a respectful and kind way to residents. Inspectors noted that the privacy and dignity of residents was well respected. Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Adequate screening curtains were provided in shared bedrooms.

A social care project which involved writing a summary of person-centred information about a resident onto paper clouds and displaying them discretely in the residents bedrooms was a respectful and effective way of communicating information that was important to the residents. This facilitated staff to communicate effectively with the residents, especially those with cognitive difficulties.

A resident meeting is held every three months. The meeting is facilitated by the activities coordinator. Residents and their families are invited to take part. The meeting is advertised with posters in prominent areas of the home. There was no independent representation for residents with dementia who may not be able to communicate their views at the meeting. While the residents' meetings are documented, the follow up actions resulting from the meeting are not documented. An action in relation to this is outlined under Outcome 8, Governance and Management.

There was an activities schedule in place and residents were observed to be socially engaged in the afternoon activity. The activities coordinator worked between the day-rooms located on both floors. Most of the scheduled activities took place in the ground floor day room. The inspectors noted that the day room on the first floor was less attractive and not as comfortable to spend time in. Residents told inspectors that they preferred the atmosphere downstairs. However, there is limited space in this dayroom. This meant that residents were restricted in exercising choice about where they spend their day due to the lack of space in the ground floor day room. The inspectors concluded that the use and layout of both rooms should be reviewed to provide residents with appropriate choices and standards of comfort.

Residents had access to television, radio and newspapers which they were seen to engage with and enjoy of the day of inspection. There were no restrictions in place in relation to visitors. Visitors were seen to come and go throughout the day of inspection. There are currently no arrangements in place to facilitate residents receiving visitors in private. The provider assured inspectors that there was a plan in place to address this issue.

The closed circuit television (CCTV) system was in place to monitor the outside area of the centre. There is a data protection policy in place.

**Judgment:**
Substantially Compliant

## *Outcome 04: Complaints procedures*

**Theme:**
Person-centred care and support

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

**Findings:**
The centre had policies and procedures for the management of complaints. Inspectors reviewed the complaints log. Two complaints had been logged in 2019. The complaints were well documented, addressed in a timely manner and recorded the satisfaction of the complainant.

Details of the complaints procedure were included in the statement of purpose and residents' guide. The complaints process had also been discussed at a recent residents forum meeting.

Residents were informed on admission of the complaints procedure. The centre had a nominated person to oversee the complaints process and also directed the complainant to the office of the Ombudsman if unhappy with the outcome. Residents spoken with on the days of inspection told the inspector that they would not hesitate to make a complaint if they had one. Relatives voiced satisfaction with the care and were aware of who they could complain to if they needed.

Inspectors noted that a complaint documented from a resident during a resident meeting was not documented or actioned as a complaint in line with the centres policy.

**Judgment:**
Substantially Compliant

## *Outcome 05: Suitable Staffing*

**Theme:**
Workforce

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

**Findings:**
Inspectors were not satisfied that there were appropriate staff numbers to meet the needs of the residents taking into account the size and layout of the designated centre.

The inspectors reviewed a sample of staff files which contained all the required documentation as required by the Regulations. Garda Síochána vetting was in place for all staff. Nursing registration numbers were available and up-to-date for all staff nurses.

A review of the call bell audit response times found that there was regular instances where residents had to wait between five and ten minutes for a call bell to be answered. A compliance plan submitted by the provider relating to previous action requirements stated that call bell audits would be assessed to ensure that care staff reply promptly to residents requests. This had not been completed.

The staffing numbers identified in the statement of purpose (SOP) did not reflect the staffing that was available to deliver care to the residents. The SOP identifies that there is a member of staff allocated to the laundry. There was no dedicated member of staff rostered for the laundry. Laundry duties are completed by care staff during their shifts which detracted from their availability to provide care to residents.

As part of the inspection, inspectors spent periods of time observing staff interactions with residents using a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at 20 minute intervals the quality of interactions between staff and residents in the communal areas. While the staff interactions that took place were positive the Inspectors observed long periods of time when residents in the upstairs day room were not supervised and did not have access to staff.

**Judgment:**
Non-Compliant - Moderate

## *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 purpose built. The premises and grounds were well maintained with

suitable heating, lighting and ventilation. The floor covering throughout the centre was safe and well maintained. There is adequate storage for resident's belongings.

Handrails were available in circulation areas throughout the building, and grab rails were present in toilets and bathrooms. The furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call bell facilities, remote control devices, hoists and mobility aids were seen in use by residents that promoted their independence. The inspectors found that the privacy and dignity of residents was promoted in each bedroom by its layout.

Corridors were seen to be clear of any obstructions. They were wide and bright and allowed for freedom of movement. Many rooms were personalised with photos, memorabilia and artefacts. There were calendars and clocks for each room to ensure that residents were orientated to time and date. Each bedroom had access to a locked press for personal belongings.

Both floors in the centre were colour themed supporting residents with dementia to find their way around. There were pictures and textured wall hangings positioned on the corridors at eye level for residents to engage with. The centre has an enclosed garden that has raised beds and facility for residents to actively participate in gardening. A greenhouse was being constructed to support a resident's hobby.

On the day of inspection the centre was clean. The inspectors had received a number of concerns in relation to the cleaning standards within the centre. The centre is actively recruiting cleaning staff and have a plan in place to monitor and uphold standards while recruitment takes place. The centre is engaging the service of an external contractor until staffing issues are resolved.

The register provider recognised the requirement for a room to be made available for residents to see their visitors in private. A plan will be submitted to the office of the Chief inspector to address the issue. This issue has been actioned under Outcome 3, Residents rights, dignity and consultation.

**Judgment:**
Compliant

## *Outcome 07: Health and Safety and Risk 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:**
A Health and safety statement was available for inspection. The centre had a risk register last that was kept under review by the management team. The register identified areas of risk within the centre and the control measures in place to minimise

any negative impact on residents. A number of gaps were identified in the risk register.

The centre was clean on the day of inspection. Staff demonstrated an awareness of good hygiene practices. However, residents and their families told the inspectors that the quality of the cleaning of the centre was inconsistent. The register provider told inspectors that the centre had experienced difficulties in the recruitment of cleaning staff. Inspectors were informed that the recruitment process was on-going.

Fire safety records were reviewed by the inspectors. There was a fire management policy in place which included detail in relation to fire management. A fire safety register was available for inspection. A record of yearly servicing of the fire safety system within the building and a record of equipment maintenance was available for review. A personal evacuation plan was in place for all residents. All staff had received training and were aware of evacuation procedures. A record of fire drills was in place which detailed the timing of compartment evacuation and lessons learned. All fire drills were unannounced.

A number of issues required review:

There was no risk assessment and management plan in place in relation to
- resident access to gloves, aprons and hazardous chemicals
- difficulties recruiting cleaning staff
- restricted access to external courtyard

**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 inspectors found that the centre was managed by an appropriate person in charge who was actively engaged in clinical management and governance in the centre. She was supported by a clinical nurse manager.

Regular staff meetings were held and documented. However, matters arising from meetings were not developed into action plans and communicated back to the staff.

A compliance action to review the call bell audit had not been completed. In addition while some progress had been made in respect of Regulation 5 on Individual

Assessment and Care Plan, further development was required to be brought into full regulatory compliance. A full review of the center's Statement of purpose (SOP) was also required in order to meet regulatory requirements.

An audit schedule was in place. The audits completed had covered a range of clinical areas. The analysis of information collected from these audits was poor and did not drive improvements in care for residents. A more robust system of audit was required. Improvements were required in:

- Analysis of information collected by the Clinical and Governance systems,
- Development of effective action plans
- Communication of plans and learning to staff.

Staffing levels required review and is detailed under outcome 5 staffing to ensure the safe delivery of care in accordance with the centre's statement of purpose and function.

**Judgment:**
Non-Compliant - Moderate

## *Outcome 09: Statement of Purpose*

**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 Statement of Purpose (SOP) for the centre did not include all the required information as set out in Regulation 3(1). The SOP had not been amended to align with the staffing numbers on the rosters. An action plan from the last inspection conveyed a similar finding.

**Judgment:**
Non-Compliant - Moderate

## Closing the Visit

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

### Acknowledgements

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

### *Report Compiled by:*

Catherine Sweeney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

**Health Information and Quality Authority**
**Regulation Directorate**

**Action Plan**

**Provider's response to inspection report**[1]

| | |
|---|---|
| **Centre name:** | Caiseal Geal Teach Altranais |
| **Centre ID:** | OSV-0005491 |
| **Date of inspection:** | 06/06/2019 |
| **Date of response:** | 16/07/2019 |

## 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 (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The needs of the residents have not been assessed.

**1. Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the

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

person's admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
All residents with evidence of cognitive decline or a diagnosis of dementia will have their care plans re-written with a detailed description of individual symptoms and triggers. Nurses have a list of assessments required to be completed within 48 hours of admission to provide the basis for all individual care plans

**Proposed Timescale:** 31/07/2019

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
No social care plan was developed for any resident. Care plans were not based on the assessed needs of the residents.

**2. Action Required:**
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
All residents have a social care plan now in place. The P.I.C. is committed to ensuring that social care plans for all residents will be in place for all residents who join the centre moving forward

**Proposed Timescale:** 03/07/2019

**Outcome 03: Residents' Rights, Dignity and Consultation**

**Theme:**
Person-centred care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There are restricted facilities for occupation and recreation.

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

**Please state the actions you have taken or are planning to take:**
Management will assess the public area in the top floor from the entrances by lift and door and including the resident's kitchenette and day room, to improve the ambiance and make the area more attractive by the introduction of extra furniture, colour

schemes, and fittings.

Since inspection on 06/06/2019, a large dining room table is added to the 1st floor (upstairs). The introduction of this additional table will encourage residents to participate in board games, drawing therapy, and to communicate as a group sitting together.
It is intended to provide a “Smart TV” to allow residents view a wider range of selected music and programmes.
The activities co-ordinator will expand the upstairs schedule of activities. Staff are reorganized to ensure that a staff member is present in the upstairs dayroom when residents are present.

**Proposed Timescale:** 30/09/2019

**Theme:**
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There are no private areas in the centre for residents to receive visitors.

**4. Action Required:**
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

**Please state the actions you have taken or are planning to take:**
As per letter and attached plans the ground floor bathroom will be converted and fitted out to provide a meeting room that will respect the dignity/privacy of our residents and their visitors.

**Proposed Timescale:** 30/09/2019

**Outcome 04: Complaints procedures**

**Theme:**
Person-centred care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A complaint made by a resident was not documented in line with the centre's complaints policy and procedures.

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

from a resident's individual care plan.

**Please state the actions you have taken or are planning to take:**
In this instance, the complaint was made and withdrawn within the meeting therefore for this reason, it was not logged in the register. Moving forward, all complaints will be investigated and reviewed by the management team on a weekly basis

**Proposed Timescale:** 31/07/2019

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Staffing levels did not reflect levels set out in the centre's Statement of purpose. Substantial delays to resident care evidenced on the day of inspection.

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

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

| Position | No of FTE Staff | Hrs Worked | Care Hours |
|---|---|---|---|
| Senior Health Care Assistants | 2.11 | 76 | 76 |
| Health Care Assistants | 16.28 | 586 | 586 |
| Activities Social Coordinator | 1.11 | 40 | 40 |
| Resident Meals Assistant | 1.75 | 63 | 63 |
| Housekeeping En suite /bedrooms | 1.94 | 70 | 70 |
| Housekeeping Laundry | 0.78 | 28 | 28 |

We propose to separate the cleaning function into 1) Housekeeping Ensuite/Bedroom which is directed at the residents health and safety benefit 70 hours per week 1.94 FTE, and 2) Housekeeping Laundry again to the benefit of the residents 28 hours, 0.78 FTE. We have placed advertisements for these vacancies and seek to have the positions filled asap. It will also ensure that laundry staff will not be drawn from the HCA's pool of staff.

**Proposed Timescale:** 30/09/2019

## Outcome 07: Health and Safety and Risk Management

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A number of gaps were identified in the risk register.

**7. 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:**
Resident access to gloves/aprons – the maintenance person will immediately raise all vendor of gloves and aprons to location above a height that may be reached by a resident by 31/07/2019
Residents access to hazardous chemicals, an order is placed for the immediate supply of cleaning trolley, used in the healthcare sector, and chemicals are under lock. Further training will be provided to the cleaners on the safety use of the cleaning trolley by 31/07/2019.
Once the weather is suitable all residents and their visitors are encouraged to visit the enclosed garden. Management will risk assess all residents as to their individual ability to visit the garden and will make a simple keypad code available to them. This keypad code will apply to the door adjoining the smoking room. As all external doors will be served by different entrance/exit codes the exterior boundaries will not be breached, and the fire certification not compromised.
A risk assessment of the enclosed garden indicates a “Black Spot” between the garden and front terrace.
A sensor camera will be placed covering this area and will form part of the overall camera coverage of the nursing home. The actions on the access to the external garden will be completed by 30/09/2019.

Recruiting Cleaning Staff – while cleaning staff are employed by the nursing home, to ensure compliance with cleaning standards, we have employed on a monthly basis outside contract cleaners to 1) maintain and support cleaning staff 2) to advise management on more effective procedures for cleaning. The cleaning contractors have advised management on a plan to allocate a dedicated person for cleaning only Ensuites and bedrooms in each floor.
Advertisements are placed on media outlets for these vacancies, the persons employed in this area will be classified as “housekeeping”, and have been identified as such in the SOP.

**Proposed Timescale:** 30/09/2019

## Outcome 08: Governance and Management

**Theme:**

Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Management systems do not ensure that care delivery is effectively monitored.

**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:**
The P.I.C and CNM will review care on a weekly basis to include events, care plans and assessments. The new Incident register will be reviewed weekly and changes to care resulting from the root cause analysis discussion will be documented within care plans and implemented. All changes to care will also be highlighted in the communication book and discussed at all staff handovers. The management team are actively pursuing electronic documentation system provider to review improving the audit process to allow for more integrated audit reports.

**Proposed Timescale:** 31/08/2019

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A review of staffing levels was required to ensure the effective delivery of care in accordance with the centre's statement of purpose.
Residents were observed to wait to have their care needs met on the day of inspection.

**9. Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
Draft Statement of Purpose incorporating staffing levels to meet residents care outlined in outcome 5.

**Proposed Timescale:** 31/10/2019

**Outcome 09: Statement of Purpose**

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory**

**requirement in the following respect:**
The Statement of Purpose (SOP) for the centre did not include all the required information as set out in Regulation 3(1).

**10. Action Required:**
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
As indicated in outcomes 05/07, a Draft Statement of Purpose will be sent to the Chief Inspector setting out how management has increased staff, reallocated staff to housekeeping.

**Proposed Timescale:** 21/07/2019