

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Castlemanor Nursing Home
Centre ID:	OSV-0000123
Centre address:	Billis, Drumalee, Cavan.
Telephone number:	049 432 7100
Email address:	info@castlemanor.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Castlemanor Nursing Home Limited
Provider Nominee:	Dermot O'Reilly
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	71
Number of vacancies on the date of inspection:	0

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.

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.

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 August 2014 08:50	13 August 2014 16:30
14 August 2014 08:45	14 August 2014 17:00

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

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

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre.

The inspector met with the provider, person in charge and members of the management team who all displayed a good knowledge of the Authority's Standards and regulatory requirements. A number of questionnaires from residents and relatives were received prior to the inspection and the inspector spoke to residents during the inspection. They were proactive in their response to the actions required from the previous inspection and all matters identified were satisfactorily completed.

The inspector were satisfied that the residents were well cared for and that their nursing and care needs were being met. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Residents had good access to general practitioners (GP). The person in charge was fully involved in the management of the centre and was found to be easily accessible to residents, relatives and staff.

The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The person in charge had sufficiently prioritised the safety of residents in the event of fire.

The inspector was not satisfied from reviewing the rota and close observation over the course of the two days of inspection a sufficient number of care assistants were rostered to meet all residents' individual and collective needs during the day. Staff were considerate in their interactions with residents while busy in meeting their care demands and could not promote freedom of choice to use the facilities of the physical environment. The numbers and deployment of staff was task allocated towards meeting the physical care needs of residents. The role of the activity coordinator requires review.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Section 41(1)(c) of the Health Act 2007. 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.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose set out the services and facilities provided in the designated centre and the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider and had been updated in April 2014.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a defined management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre.

The provider attends the centre on a routine basis and assisted in facilitating the inspection. He outlined his role to the inspector as supporting the person in charge, managing finances and overseeing maintenance and the governance operations of the centre. There is reporting system in place to demonstrate and communicate the service is effectively monitored and safe between the person in charge and the service provider. The provider was familiar with residents and informed of any specialist care needs by the person in charge.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge. A system of audits is planned on an annual basis to include clinical data over a wide range of areas namely medication management, nutrition and any accident/falls sustained by residents,

The inspector found that this information was used to improve the safety of care in relation to the management of falls. The number and times of falls were identified. Residents who had repeat falls were identified and individual strategies implemented to minimise the risk of repeat occurrence. Residents were provided with sensor alarms and another had a medication review to determine underlying factors.

Monitoring systems require further development by the provider to ensure a more robust consistent approach in line with the requirements of regulation 23. Improvement plans to ensure enhanced outcomes for residents were not developed in a similar manner for other areas audited. The type of information collected for example, in medication management and the procedure to review the clinical data collected required further development to assist in identifying observation of trends to lead to enhanced outcomes for residents. The quality assurance program required further expansion to review additional areas which impact on resident's wellbeing.

Annual reviews of the quality and safety of care were not undertaken in consultation with the residents and their families and copies of reports were not made available to residents.

Judgment:

Non Compliant - Minor

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 found that each resident had an agreed written contract which included details of the services to be provided for that resident and the overall fees to be charged. The inspector reviewed a sample of three contract of care to include the contract for the resident mostly recently admitted to the centre. All contracts were signed by relevant parties.

The overall fee was noted on the contract. Charges payable per all items not included in the overall fee were outlined for all additional expenses incurred by residents clearly in the contract of care for example, chiropody, hairdressing, prescription charges.

There was a residents' guide developed containing all the information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy, the services provided and the complaints procedure.

Judgment:

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 has not changed since the last inspection. She is a registered nurse and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs and confirmed she assists in the delivery of clinical care and is detailed on the roster to ensure she is apprised of each residents care needs. There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge.

The person in charge maintained her professional development and attended mandatory training required by the regulation in fire evacuation, safe moving and handling of residents and adult protection. She is a qualified trainer for adult protection, promoting a restraint free environment and cardio pulmonary resuscitation. She had attended courses on end of life care and dementia care.

There is a key senior manager notified to the Authority to deputise in the absence of the person in charge. The arrangements and reporting systems were known to staff an outlined in the statement of purpose.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

The inspector found that medical records and other records, relating to residents and

staff, were maintained in a secure manner. Appropriate insurance cover was in place with regard to accidents and incidents, out sourced providers and residents' personal property.

The directory of residents contained all the information required by schedule three of the regulations and was maintained up to date.

A sample of six staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

Judgment:

Compliant

Outcome 06: Absence of the Person in charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. The key senior manager was appointed to deputise while the person in charge was absent. To date this has not occurred.

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:

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The policy was specific to the centre and revised since the last inspection as it was an area identified for improvement in the action plan. The revised policy contained clear procedures to investigate any allegation of suspected or confirmed abuse to include details of protection of the residents while the matter was being investigated. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse and the contact details of the HSE, senior case worker for adult protection were documented in the policy.

Residents spoken with stated that they felt safe in the centre and questionnaires received from relatives further confirmed they feel their family member is safe. There was a visitors log in place and entrance and exit doors were monitored by CCTV. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre.

The person in charge is a qualified trainer in adult protection. Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming all staff had refresher training in protection of vulnerable adults and further training was planned for 2014. Garda Síochána vetting had been applied for all staff members.

The financial controls in place to ensure the safeguarding of residents' finances were examined by the inspector. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. A petty cash system was in place to manage small amounts of personal money for residents. A record of the handling of money was maintained for each transaction. Two signatures were recorded for each transaction. The ongoing balance was transparently managed. The provider is a designated agent to manage pensions for 11 residents. This arrangement was made in consultation with residents and their next of kin. An accountable system was in place for the management of money collected by the provider on behalf of residents.

There is a policy on the management of behaviour that is challenging and supportive strategies were in place. Where residents had specialist care needs such as mental health problems there was evidence in care plans of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum therapeutic values. This was evidenced by a review of medical notes where treatment plans were outlined.

Staff spoken with were very familiar with resident's behaviours and could describe the particular interventions well to the inspector. However, all staff had not received training in behaviours that challenge to ensure they have up to date knowledge and skills to respond appropriately.

Judgment:

Non Compliant - Minor

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The actions in the previous inspection which related to risk and health and safety were satisfactorily completed. Thermostatically controlled valves were fitted to all dispensing hot water outlets in residents' ensuite bedrooms. An improved system of safety audits was introduced to check for hazards and minimise identified risk to promote resident safety.

Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy. The health and safety statement was updated in June 2014. The risk management policy contained the procedures required by the regulation 26 and schedule 5 to guide staff.

The Authority was provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent older people in advance of this inspection.

The person in charge had sufficiently prioritised the safety of residents in the event of fire. The inspector read the records which showed that inspections of fire exits were undertaken. The fire alarm was sounded weekly and automatic door closer were checked to ensure they were operational. The fire extinguishers were checked to ensure equipment was in place and intact. The inspector viewed contracts which indicated the fire alarms; smoke and heat detectors were checked and serviced routinely and fire extinguisher serviced annually. Evacuation sheets were fitted to the beds of all residents and the escape route plans were provided to indicate the direction to the nearest fire exit. Fire training for staff was completed annually by an accredited trainer. Records indicated staff participated in fire drill practices to reinforce their theoretical knowledge from annual fire training. Staff interviewed could explain to the inspector, how they would evacuate residents safely in the event of a fire. This was an area identified for improvement on the last inspection.

A risk assessment was completed for residents who smoke to ensure they were safe to smoke independently or outline the level of assistance and supervision these residents might require in a plan of care. Cigarettes and matches were held in safe keeping by staff. It was observed one resident refused to wear a fire retardant apron when smoking. This was not outlined in the resident's smoking care plan and consequent possible risk posed. Details of other actions required to ensure the resident's safety were

not specified in the plan of care.

The training records showed that staff had up-to-date training in moving and handling. The moving and handling instructor had changed from an external contracted trainer to a staff member who had qualified as a moving and handling trainer. There was sufficient moving and handling equipment available to staff to meet residents needs. A validated moving and handling risk assessment tool was utilised to determine each residents' moving and handling needs in an evidenced based manner. Each resident's moving and handling needs were identified and available to staff at the point of care delivery in bedrooms outlining whether a resident required the assistance of a hoist or one or two staff members. Where a resident requires a hoist; the type of hoist was specified to include details of the sling type and size. This was an area identified for improvement on the last inspection.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Records sheets were available to record neurological observations where a resident sustained an unwitnessed fall or a head injury. Individual strategies were outlined and utilised to minimise the risk of residents sustaining a fall to include, sensor mats placed on the floor outside beds and on chairs, low-low beds and hip protectors.

Judgment:

Non Compliant - Minor

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible and distinguished between regular and short term medication. A record of medical reviews by GP's was documented in the drug kardex folder. This system allowed for clear checks to ensure regular and appropriate medical care provision. This was an area identified for improvement on a previous

inspection.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medication was being crushed for some residents prior to administration due to swallowing difficulty by the residents. Links were established with the pharmacist and where possible a liquid or dispersible form of the medication was obtained. There was consent for crushing signed by the GP on the top of the prescription chart. However, medications were not prescribed for crushing individually on the prescription sheet. The practice of prescribing crushed medication as a broad statement on the top of the prescription page rather than individually to the specific medication being crushed is not in line with best practice.

Medicines were being stored safely and securely in the clinic room which was secured. The temperature ranges of the medicine refrigerator was being appropriately monitored and recorded.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

Judgment:

Non Compliant - Minor

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 reviewed a record of incidents/accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority 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 arrangements to meet residents' assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments.

The inspector reviewed three resident's care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, forms of restraint in use, potential behaviour that challenges and residents under palliative care. The inspector found that all files reviewed were comprehensive. In the sample of care plans reviewed there was evidence care plans were updated at the required three monthly intervals or in a timely manner in response to a change in a resident's health condition.

A range of risk assessments had been completed and were used to develop care plans that were person-centred, individualised and described the current care to be given in the main. Care plans for residents with dementia or cognitive impairment required review to ensure they are more person centred. In some instances the inspector found that while the degree of confusion was outlined for example "severe cognitive decline" there was no information that indicated how this impacted on daily life. Information such as who the resident still recognised or what activities could still be undertaken which guide staff would practice was not always evident. There was documentary evidence that residents or their representative were involved in the development and review of the resident's care plan and that residents and their relatives had been consulted about their care and treatment. Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector.

Residents had access to GP (General Practitioner) services and there was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. A review of residents' medical notes showed that GP's visited the centre regularly. The GP's reviewed and re-issued each resident's prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals to include speech and language therapist, dietetic service and occupational therapy was available to residents on referral. Where residents had specialist care needs such as mental health problems there was evidence in care plans of good links with community mental health services. The consultant psychiatrist and their team visit the centre as required to review residents. Medication is reviewed to ensure optimum therapeutic values. There were no residents with pressure wounds on the day of inspection.

Judgment:

Non Compliant - Minor

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):

No actions were required from the previous inspection.

Findings:

The building is designed to meet the needs of dependent older people. The building is well maintained both internally and externally. It was found to be clean, comfortable and welcoming. There was a very high standard of décor throughout and good levels of personalisation evident in residents' bedrooms. Residents spoken with confirmed that they felt comfortable in the centre.

Each unit has its own day sitting room. There is a large recreational room, an art and computer room, a multi-sensory room, visitors, room, hair salon and an oratory. A number of auxiliary rooms for storage, laundry and a main kitchen are included in the design. All parts of the building were comfortably warm, well lit and ventilated.

Bedroom accommodation consists of 69 single and one twin bedroom, all with en suite toilet and shower facilities. Bedrooms are suitable in size to meet the needs of residents. There is a call bell and over bed lamp located by each resident's bed. Toilets were located close to day rooms for residents' convenience in addition to four assisted bathrooms with a bath and toilet facilities. All bedrooms and en suites have good natural light and are suitably ventilated.

Staff facilities were provided with space for the storage of personal belongings. Separate toilets and showering facilities were provided for care and kitchen staff in the interest of infection control. A separate cleaning room, sluice areas and laundry is

available.

Judgment:

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):

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

Findings:

There was a comprehensive complaints policy in place. This was revised since the last inspection as the complaints administrative procedures were not meeting the requirements of the regulations. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

The inspector reviewed the complaints procedure and noted this displayed inside the main entrance. A designated individual was nominated with overall responsibility to investigate complaints. A nominated person who would monitor that the complaints process was followed and recorded (independent of the person responsible to investigate the complaint) was identified.

There were robust internal mechanisms within the centre's policy to resolve complaints. The timeframes to respond to a complaint, investigate and respond to complainant were outlined. There was an independent appeals process if the complainant was not satisfied with the outcome of their complaint.

No complaints were being investigated at the time of inspection. A complaints log was in place which contained the facility to record all relevant information about complaints. There was evidence complaints were resolved to the satisfaction of the complainant.

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:

End of life care formed an integral part of the care service provided at the centre. Questionnaires, asking relatives' opinions regarding end-of-life care, were sent to the relatives of deceased residents. All responses reflected a high level of satisfaction with the care received and the communication between families and staff.

There was an end-of-life policy in place. The policy reviewed included procedures to guide staff on documenting resident's wishes in relation to end of life, the right to refuse treatment and information on referral to palliative care services for specialist input. Staff spoken with had an understanding of end of life care and 38 staff had completed training in this area during 2014. Further training on end of life care is required for staff to promote their professional development in providing care for residents at end of life.

The policy of the centre is all residents are for resuscitation unless documented otherwise. The end of life plans included discussions in relation to life sustaining treatments. Residents were consulted regarding their future healthcare interventions, personal choices and wishes in the event that they became seriously ill and were unable to speak for themselves. A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. However, residents with a do not resuscitate (DNR) status in place did not have the (DNR) status regularly reviewed to assess the validity of clinical judgement on an ongoing basis. In medical files reviewed one resident's (DNR) status was not reviewed since January 2013.

Where the need was identified referrals were made to the palliative care team. Records reviewed evidenced good input by the palliative team to monitor and ensure appropriate comfort measures. Medication was regularly reviewed and closely monitored to ensure optimum therapeutic values. The person in charge had a validated pain assessment tool available.

The person in charge stated that upon the death of a resident, his/her family or representatives were offered practical information (verbally) and on what to do following the death of their relative. An information leaflet on how to access bereavement and counselling services is available and these were on display in the entrance foyer. There was a protocol for the return of personal possessions.

Care practices and the facility of the physical environment ensured that resident's needs

were met and their dignity respected. Sixty nine of the 71 residents are accommodated in single bedrooms. Families are supported to be with their relative and facilitated to stay overnight. There is a visitor's room on the ground floor with sofa bed and coffee dock where refreshments are available to visitors. Residents' cultural and religious needs were supported. There is a large oratory available to residents to meet their spiritual needs.

Judgment:

Non Compliant - Minor

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a food and nutrition policy in place which was centre specific and provided detailed guidance to staff.

Residents spoken to during the visit and relatives in questionnaires returned to the Authority expressed satisfaction with the food provided and the choices available to them. The menu was planned on a weekly basis and all food was cooked on the premises. The inspector reviewed the menu and discussed options available to residents with the chef. There were nutritious snack options available between meals to ensure sufficient or optimum calorific intake particularly those for those on fortified diets. A trolley served residents mid morning offering a choice of tea/coffee and biscuits. In the afternoon residents were offered a fruit option, with some bread or biscuits. A light supper was offered to residents and includes a variety of sandwiches, milk pudding or cereals.

The inspector observed breakfast and the main lunchtime/dinner meal. Almost all residents had breakfast in their bedrooms. A choice of eating in the dining room was not available at breakfast time. This is discussed in more detail under outcome 18 Suitable Staffing. The lunch time meal was in the large dining on the first floor for the majority of residents and a separate dining room was available to residents in the dementia care unit. This meal time was a social occasion and a calm environment was ensured. The dining areas are well decorated with a bright decor. The lunch time menu provided residents with a good choice of nutritious, wholesome foods. Soup was served as the first course and then the main meal. Consideration or the option of offering all residents soup earlier prior to their main meal was not explored to ensure residents has sufficient capacity to consume their main lunch time meal.

Pictorial menus were available to assist residents in their choosing their food options. The menu choices were displayed on a board in the dining room. However, the writing was small and not easily distinguishable. Menus were not on the tables in the dining rooms. All residents were required to confirm their menu choices for all meals in the afternoon time a day in advance of having their meals. This practice is not reflective of person centre care.

Residents food likes and dislikes were recorded and served meals in accordance with their preferences and dietary restrictions. The inspector noted that food including food that was pureed was presented separately and in accordance with the menu of the day. The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff. Staff interviewed could describe the different textures and the residents who had specific requirements.

Sufficient dining space was available. Tables accommodated small groups of residents which supported social interaction. The inspector saw that there were adequate staff available to assist at mealtimes. Staff sat with residents who required assistance with meals, were respectful with their interventions and promoted independence by encouraging residents to do as much as they could for themselves.

Residents had care plans for nutrition and hydration in place. There was prompt access to the GP and allied health professionals for residents who were identified as being at risk of poor nutrition or hydration. There was ongoing monitoring of residents nutritional, hydration and skin integrity. Nutritional screening was carried out using an evidence-based screening tool at a minimum of three-monthly intervals. Each need had a corresponding care plan which detailed the nursing care, medications/food supplements prescribed; specific care recommendations from visiting inter disciplinary team members and the general practitioners instructions. Staff monitored the fluid intake of all residents. Fluid charts were totalled. However, there was not a system in place to review records and ensure each resident's daily fluid goal was maintained and allow for intervention at the earliest stage possible if issues arose.

Twelve care assistant and five nurse's staff had received training in relation to food and nutrition. They demonstrated and articulated good knowledge of how to provide optimal care for residents. However, all staff were not trained on nutritional care for the elderly.

Judgment:

Non Compliant - Minor

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 evidence of a good communication culture amongst residents, the staff team and person in charge. Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents' civil and religious rights were respected. Residents and staff confirmed that they had been offered the opportunity to vote at each election either in house or their own locality. Residents could practice their religious beliefs. There was a visitor's room to allow residents meet with visitors in private.

Residents had access to a variety of national and local newspapers and magazines to reflect their cultural interests and heritage. These were located in easily accessible areas and available to residents daily. A residents' forum was in place and the person in charge had completed a satisfaction survey by requesting residents and relative to complete questionnaires.

There was an activity coordinator employed who undertook an activity program in the large upstairs day sitting room from 13:30 hrs to 15:30 hrs. However, as this room accommodates generally 40 residents in the afternoon and the coordinator does not have the support of a care assistant, her role is essentially occupied in supervising residents and meeting their physical care needs. This is discussed in more detail under outcome 18 suitable staffing. Residents who do not retire to their bedrooms for a rest are required to remain in this sitting room and do not have the option to utilise the smaller sitting rooms as there is not staff deployed to monitor and assist residents in these areas in the afternoon. Consequently some residents with mild cognitive impairment or those who do not wish to retire to their bedrooms but would benefit from a smaller group social setting, occupy the time of the activity coordinator. Other residents with a risk of falling or who have sensor alarms on their chairs and who mobilise in the room require the attention and assistance of the activity coordinator and detract from the activity program for the majority of residents eroding the role of the activity coordinator.

Judgment:

Non Compliant - Major

Outcome 17: Residents' clothing and personal property and possessions

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed a policy for the managing of residents' personal property. It provided guidance to staff on the storage and care of residents' belongings. There was evidence that residents had adequate space for their belongings, including secure lockable storage. Each resident was provided with their own wardrobe. The centre provided the service to laundry all residents' clothes and families had the choice to take home clothes to launder if they wished.

A staff member was assigned to the laundry each day of the week. However, a robust clear system was not in place to ensure all clothes were identifiable to each resident. The inspector checked items of clothing in the laundry and residents wardrobes and noted names were not recorded on all clothing. Rooms number were indicated in many cases which is not respectful to resident personal clothing. In some cases the name or number in ink pen was illegible due to the washing process.

A property list was completed with an inventory of all residents' possessions on admission. However, some residents did not have an updated property list from the time of their initial admission. The inspector noted that resident's bedrooms were personalised with many of the rooms decorated with pictures and photographs.

Judgment:

Non Compliant - Minor

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):

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

Findings:

The provider employs a whole-time equivalent of 19 registered nurses and 36.49 care assistants. In addition, there is catering, cleaning, laundry, maintenance and an activity coordinator employed. The inspector viewed the staff duty rota for a two week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty.

There was a sufficient number of nursing staff rostered during the day and an adequate level of care assistants and nursing staff for night duty. However, the inspector was not satisfied from reviewing the rota and close observation over the course of the two days of inspection a sufficient number of care assistants were rostered to meet all residents' individual and collective needs during the day. There were 35 residents with maximum care needs and 16 residents highly dependent. There are 23 resident requiring the use of hoist or two carers to assist with mobilising. Residents were not able to exercise choice regarding where they would like breakfast and no residents came to the large dining room on the first floor for breakfast.

Residents were not facilitated to move freely around the building and use communal areas of their choice during the day as described under outcome 16 residents' right dignity and consultation. Staff levels in the dementia unit were adequate to meet residents' needs and residents occupied all the communal areas throughout the day from early morning. Residents in the Sheelin unit moved to the small sitting room throughout the morning as they were assisted to get up and have breakfast. However, the majority of the residents on the first floor remained in their bedrooms until they were assisted to the dining room for their lunch time meal. This was their first opportunity during the day to socialise with other residents. The large day sitting on the first floor remained unoccupied throughout the morning time of the days of inspection. Staff were considerate in their interaction with residents while busy in meeting their care demands and could not promote freedom of choice to use the facilities of the physical

environment. The numbers and deployment of staff was task allocated towards meeting the physical care needs of residents and did not allow for person centred outcomes for residents to facilitate choice and flexibility in their activity of daily living. There was no sensory/cognitive or physical stimulation for residents in the two units on the first floor which accommodate a total of 44 residents and the Sheelin unit on the ground floor in the morning time.

There was a training matrix available which conveyed that staff had access to on-going education and the range of professional development training was provided. The inspector found that staff had attended training sessions in addition to the mandatory training required by the regulation to ensure their continuous professional development. Staff had received training on infection prevention, caring for residents with dementia and end of life care. However, as identified under outcome seven safeguarding and safety all staff had not received training in behaviours that challenge. Further training on end of life care and nutrition and the elderly was identified as an area for improvement.

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. Staff confirmed to the inspector they undertook an interview and were requested to submit names of referees. There was an appraisal system in place to review and discuss each staff member's professional development.

A record of An Bord Altranais PINs (professional identification numbers) for all registered nurses was maintained.

Judgment:

Non Compliant - Major

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



Provider's response to inspection report¹

Centre name:	Castlemanor Nursing Home
Centre ID:	OSV-0000123
Date of inspection:	13/08/2014
Date of response:	29/09/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Monitoring systems require further development by the provider to ensure a more robust consistent approach in line with the requirements of regulation 23. Improvement plans to ensure enhanced outcomes for residents were not developed in a similar manner for all areas audited.

Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

We are improving our existing monitoring system by collating the data and statistics we have collected in all areas to establish baselines, identify trends, provide actions plan and evaluate outcomes which will guide us in providing Safer and better quality of care for our residents

Proposed Timescale: Improvement to our existing monitoring systems commenced since September and aim to have analysis completed in all areas for December 31st 2014. Our report will be made available for all residents and their next of kin on this date.

Theme:

Governance, Leadership and Management

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

Annual reviews of the quality and safety of care were not undertaken in consultation with the residents and their families.

Action Required:

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

We aim to publish our report On Quality and Safety by December 31st 2014, and invite feedback from all residents and next of kin and from Residents Forum. This will then be evaluated and included in final report after 3 months by March 31st 2015

Proposed Timescale: 31/03/2015

Theme:

Governance, Leadership and Management

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

Copies of reports from reviews were not made available to residents.

Action Required:

Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

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

All residents will be provided with a copy of the report on Safety and Quality of Care for 2014 within 3 months after year end. The Residents Forum will be provided with a copy for reference.

Proposed Timescale: 31/03/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

All staff had not received training in behaviours that challenge to ensure they have up to date knowledge and skills to respond appropriately to behaviours that challenge.

Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

In house training on Behaviours that may Challenge scheduled for October as part of our annual training programme for all staff who have not yet attended this year.

Proposed Timescale: Training on 1st and 7th of October arranged. Completed by November 30th 2014.

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:

One resident refused to wear a fire retardant apron when smoking. This was not outlined in the resident's smoking care plan and consequent possible risk posed. Details of other actions required to ensure the resident's safety were not specified in the plan of care.

Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

All residents who smoke have had their smoking care plan reviewed and updated to include compliance or not, with wearing smoking apron. At risk residents who do not wear smoking Apron are monitored while smoking by providing additional checks. Smoking rooms have doors with window to allow closer monitoring by staff. Call bell provided, fire retardant furniture provided.

Proposed Timescale: 30/09/2014

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:

Medications were not prescribed for crushing individually on the prescription sheet.

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:

Drug prescribing Kardex has been updated to include parameter for GP to state and sign where each individual medication needs to be crushed.

Proposed Timescale: All current drug kardex are being updated since September and will be completed by end of October when all GP's will be reviewing residents' medications on 3 monthly basis. To be completed by October 31st 2014

Proposed Timescale: 31/10/2014

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Care plans for residents with dementia or cognitive impairment required review to ensure they are more person centred.

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 Dementia Pathway assessment tool has been developed to monitor the Cognitive Function of Residents with Dementia. This has been adapted from the Alzheimers Society of Ireland. Implemented for all residents with Dementia. This is reviewed 3 monthly and care plans are updated according to the changes identified or on 4 monthly basis.

Proposed Timescale: 07/09/2014

Theme:

Effective care and support

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

Fluid charts were totalled. However, there was not a system in place to review records and ensure each resident's daily fluid goal was maintained and allow for intervention at the earliest stage possible if issues arose.

Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

An auditing system is in place on Epiccare which captures resident's intake and output over 24hour period. The information has been recorded by staff and we have commenced auditing and providing a report daily at 8am in all areas for staff to identify at risk residents and ensure increased fluid intake where required.

Proposed Timescale: 15/09/2014

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

Residents with a do not resuscitate (DNR) status in place did not have the (DNR) status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The rationale for each resident's DNR status is determined by their GP and review date will be included in accordance with the rationale. This may be 3 montly, 6 monthly or annually. GP's have been requested to provide clarity on the DNR review in Nursing home settings as the NATIONAL CONSENT POLICY does not advise any specific times for reviews. All current DNR'S will be reviewed and going forward will be reviewed in accordance with GP rationale as documented. We are working with residents' GP's and HSE to develop a DNAR format appropriate to the nursing home environment.

Proposed Timescale: 31/12/2014

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

Soup was served as the first course and then the main meal. Consideration or the option of offering all residents soup earlier prior to their main meal was not explored to ensure residents has sufficient capacity to consume their main lunch time meal.

Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

Current practice facilitates soup being offered with midmorning tea trolley. Some residents may avail of this option. In Lough Inchin, all residents had declined to have soup mid morning and opted for soup with main meal. Some residents in Lough Rann have soup mid morning. Soup is now provided on midmorning tea trolley and all residents have the choice of soup or tea. Those who wish to have soup with main meal are catered for. There are a number of residents who do not have soup in accordance with SALT recommendations

Proposed Timescale: 14/09/2014

Theme:

Person-centred care and support

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

The menu choices were displayed on a board in the dining room. However, the writing was small and not easily distinguishable. Menus were not on the tables in the dining rooms. All residents were required to confirm their menu choices for all meals in the afternoon time a day in advance of having their meals. This practice is not reflective of person centre care.

Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

Menu will be displayed on blackboard in larger format. The daily menu is already available in each dining room and pictorial menu also provided. This will be provided to residents in the dining room who cannot read notice board. Individual menus on tables

will not be provided at this time but will be reviewed pending outcomes and feedback. A menu display at the entrance to the dining room is also being provided.

Proposed Timescale: 14/09/2014

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The activity coordinator does not have the support of a care assistant, her role is essentially occupied in supervising residents and meeting their physical care needs.

Action Required:

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

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

Activity coordinator practices have been changed. Protected time for an activity coordinator has been provided by introducing a shift from 10am -8pm daily x 7 days a week. This means that the co-ordinator is not responsible for supervision only and allows her flexibility and autonomy in her role. The activity coordinator is developing a programme which facilitates the needs of residents in a person centred manner, in smaller groups appropriate to cognitive status, ability and interests. One on one sessions will be provided for. The wholtime equivalent for activity coordinator was 1.38 and is now increased to 2.74 a week.

Proposed Timescale: 15/09/2014

Theme:

Person-centred care and support

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

Residents were not facilitated to move freely around the building and use communal areas of their choice during the day. Residents who do not retire to their bedrooms for a rest are required to remain in this sitting room and do not have the option to utilise the smaller sitting rooms as there is not staff deployed to monitor and assist residents in these areas in the afternoon.

Action Required:

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

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

We have implemented Primary Care Model starting in Lough Rann to improve choice and person centred care for residents. This will be evaluated over a 2 week period and

then will be continued throughout L Inchin and L Sheelin. There has been an increase in care hours from whole time equivalent from 35.49 to 38.07 per week. With the implementation of protected Activity Co-ordinator hours every day, residents will have the choice to partake in activities which are now being provided using the many areas available ie activity room, sitting rooms and Media/art room throughout the whole day. With the provision of additional care hours, the care assistants will now have more time to assist the Activity Co-ordinator in her role at different times of the day. On September 22nd additional 2 care hours provided with allocation of Primary care to L Inchin.

Proposed Timescale: Commenced on September 15th 2014 and will be evaluated over 2 week period, then implemented to other areas on 29th September. October 31st 2014 completed

Theme:

Person-centred care and support

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

A choice of eating in the dining room was not available at breakfast time.

Action Required:

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

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

Residents who wish to have their breakfast in the dining rooms will be facilitated as per choice. This will evolve with the introduction of Primary care and changes to routines and work practices but all staff are enthusiastic and committed to promoting a better experience for residents.

Proposed Timescale: 31/10/2014

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

A robust clear system was not in place to ensure all clothes were identifiable to each resident.

Action Required:

Under Regulation 12(a) you are required to: Ensure that each resident uses and retains control over his or her clothes.

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

We are currently exploring a button type system for clothing identification and have

made contact with the company.

Proposed Timescale: 31/12/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

A sufficient number of care assistants were not rostered to meet all residents' individual and collective needs during the day. The numbers and deployment of staff was task allocated towards meeting the physical care needs of residents and did not allow for person centred outcomes for residents to facilitate choice and flexibility in their activity of daily living.

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:

Primary Care with appropriate skill mix of staff has been implemented and introduced on phased basis to nursing home with additional care hours provided to meet the individual and collective needs of the residents. This is simultaneous to protected Activity Co-ordinator hours every day. Evaluation ongoing with feedback over 2 week period to establish areas that may need improvement or adjustment, and change in deployment of staff accordingly.

Additional care hours to first floor per day 9.5, whole time equivalent 1.7.

Activity Coordinators hours increased from 54 care hours a week, whole time equivalent 1.38, to 107 hours per week, whole time equivalent to 2.74.

Proposed Timescale: Commenced from September 15th, complete date October 31st.

Theme:

Workforce

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

All staff were not trained on end of life care and nutrition and the elderly.

Action Required:

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

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

Annual training programme for End of Life and Nutrition and the Elderly will be provided

for remainder of staff. Scheduled for October 1st and October 7th.

Proposed Timescale: 30/11/2014