

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	The Croft Nursing Home
Centre ID:	OSV-0000028
Centre address:	2 Goldenbridge Walk, Inchicore, Dublin 8.
Telephone number:	01 454 2374
Email address:	info@silverstream.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Croft Nursing Home Limited
Provider Nominee:	Joseph Kenny
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	38
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:
20 August 2014 10:00	20 August 2014 20:00
21 August 2014 08:00	21 August 2014 15:30

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

The purpose of the inspection was to inform the decision in relation to the application by the provider to renew the registration of the centre. All documentation required for the registration process was provided.

The inspector also reviewed the actions from the previous inspection which took place on 25 June 2013. The inspector found that of the eight actions identified six had been satisfactorily completed and some actions had been taken on all others. The provider has submitted a plan for the reduction in numbers of two multi-occupancy rooms to ensure compliance with the Standards and Regulation for July 2015. This plan involves a reduction of one bed in one room and the extension of the

second room to provide one single room and one double room of the required size. The time frames for the alteration of these bedrooms had not expired. The provider currently provides accommodation for 38 residents.

The findings of the inspection demonstrate that the provider is in overall compliance with the regulations with some improvements required. Resident's healthcare was met to a good standard with good access to a range of multidisciplinary services. There was evidence of effective governance systems in place to monitor and review the quality and safety of care. Fire safety management systems were good. Mandatory training requirements including fire safety had been completed. Staff were very knowledgeable on the residents care needs and observed being attentive and respectful to them. Complaints were managed appropriately and there were appropriate protective mechanisms in place including the regular availability of an advocate.

The inspector reviewed questionnaires from residents and relatives prior to the inspection which were very positive and comments made by residents included the care is very good; staff and the manager were very kind and attentive.

Some improvements were required in the following areas:

the number of nursing staff on duty at night
timely referral of residents to specialist services with particular reference to wound care
care plans for the support of residents with behaviour that challenges or dementia
activities for residents pertinent to their capacity
communication systems for residents with dementia.

Some improvements were also required in risk management procedures such as the procedure for residents going absent and the directions available to guide staff in the safe use of the hoist and manual handling

An additional action was identified in relation to the premises which is the availability of the required number of shower/ bathroom facilities for the number of residents.

The actions required to ensure compliance with the Standards and Regulations are detailed at the end of this report.

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 had been forwarded to the Authority as part of the application for registration. It was found to be in compliance with the regulatory requirements. Admissions to the centre and care practices implemented were congruent with the statement.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider was in substantial compliance with this requirement. The provider had implemented a number of effective governance arrangements to ensure that residents care and safety is prioritised. This included a suitably qualified and experienced operations manager who oversaw the work of the person in charge including the support of a suitable qualified and experienced operations manager. The operation manager meets with the person in charge on a formal basis monthly and a written report is provided weekly. He is also present in the centre on a weekly basis. There are

also formal liaison systems between the various directors of nursing in the organisations other centres. There are effective risk management and quality assurance systems in place.

A number of systems are used including audits, regular health and safety meetings clinical governance meetings also support the governance. Reviews take place on a monthly basis of incidents, nutrition, falls, wounds and medication errors. The collated information is further audited by the operations managers and overall trends increases or reductions identified. The person in charge had also undertaken audits on care plans and residents involvement in their care. Examination of the documentation and cross referencing with residents care plans indicated that the information collated was used to implement changes to structures and systems where any deficits were identified. Examples of such issues included increased supervision and identification of residents at risk of falls or with challenging behaviours. A survey of resident and relatives was undertaken in 2014. The resources available including staffing, management structures and equipment were seen to be well utilised. The information collated provides the data for the annual report.

Judgment:

Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was resident's guide available and each resident was provided with a contract for care which was signed within one month of admission. However, while fees and outlined in the contract there is a generic additional charge the purpose of which is not identified.

Judgment:

Non Compliant - Minor

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was suitably qualified and with considerable experience in the care of residents with dementia and challenging behaviours. She took up the post in January 2014. She had continued her professional development training in mental health, palliative care and management. She demonstrated competence in her role and was engaged full time in post. She is supported by a team consisting of an assistant director of nursing who was also full time in this post. Governance arrangements, including monitoring of practices and reporting systems were clearly outlined and satisfactory and responsibilities were understood. The operations manager and person in charge were observed to be well known to the residents and relatives and were knowledgeable on their care needs and preferences.

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 the records required by regulation in relation to residents, including medical records, nursing and general records were up to date, easily retrieved and maintained in a manner so as to ensure completeness. A visitors log was maintained. All of the required policies were in place and systems to ensure relevant staff were aware of them were evident. The policy on missing persons required review and this is actioned under Outcome 8 Health and Safety. Documents such as the residents guide and directory of residents were also available. There was facilities for the storage of records for the required time frames. The inspector saw that insurance was current and included the liability for resident's personal property or injury as required by the regulations. Reports of other statutory bodies were also available.

Written evidence of compliance with the statutory fire authority had been forwarded to the Chief Inspector as part of the application for registration. However, the information provided in staffing records was not complete in terms of employment history and clarification of gaps in employment history.

Judgment:

Non Compliant - Minor

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:

Inspectors were informed that no periods of absence had occurred over and above the normal annual leave periods which required notification to the Authority. The provider has made suitable arrangements for periods of absence of the person in charge with the appointment and nomination of a suitably qualified and experienced nurse. In any absence of the person in charge the nominated person undertakes the duties and roster of the person in charge in a supernumerary capacity. All the required documentation has been forwarded to the Authority. The provider has also complied with his responsibilities to notify the Authority of the change to the person in charge which occurred in January 2014. Arrangements were suitable and consistency of management was provided for.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the policy and procedures on the prevention, detection and reporting of abuse and found that some improvements were required in its content. It demonstrated an understanding of the providers responsibilities and the function of statutory agencies. The policy however was entirely focused on the procedure to be followed in the event of an allegation against a staff member and does not provide guidance in the event of an allegation or concern in regard to any other persons. The provider was already in the process of reviewing this aspect of the policy. A review of records also demonstrated that the person in charge and staff had acted appropriately where any concerns were raised. Records demonstrated that all staff had received updated training in the prevention, detection and response to abuse. This training is ongoing, facilitated internally on a rotating basis.

Staff spoken with demonstrated an understanding of the indicators of abuse and their own responsibilities in relation to this. They also expressed their confidence in the person in charge to act on any concerns raised. Residents and relatives informed the inspector that they felt safe and very well cared for in the centre. They were familiar with the person in charge and expressed their confidence in being able to address any issue here.

A review of a sample of records of fee payments and transactions for residents including a number of residents for whom the provider acts as agent found that the records were transparent. The required documentation was in place and residents could at any time be given a detailed statement of their finances including fee payments, or monies held on their behalf. All transactions were detailed and itemised. Where it was possible residents signed these themselves or relatives signed on their behalf.

Twenty four of the residents have a diagnosis of dementia, with a number of residents also suffering from enduring mental health issues. There was a policy on the management of behaviours that challenge which was in accordance with national policy and guidelines and outlined the need to identify the underlying causes of behaviours and provide proportionate and adequate responses. A review of a sample of care plans for residents demonstrated very person-centred and specific guidelines for residents who demonstrated such behaviours. This was not a consistent finding however in terms of all of the care plans. In practice staff were able to articulate an understanding of the resident's behaviours and showed insight into non verbal behaviours including facial expressions. Individual strategies to support residents were implemented. For example, two staff carry out personal care in some circumstances which helps to minimise the anxiety for the resident or staff individually supervise a resident in order to prevent agitation which might lead to injury causing injury. Staff were observed to filter interactions with other residents to prevent distress.

There was evidence of multidisciplinary review from psychiatry of old age. Charting of incidents was undertaken to identify triggers. There was evidence of ongoing review of any medications used, for example to reduce anxiety and the impact on the residents of such medication. Staff were observed to be patient, and watchful of the residents. The action in relation to the assessment for the use of methods of restraint such as bed rails identified at the previous inspection had been satisfactorily addressed. A risk assessment was undertaken and where the use of a bed rail was contra-indicated it was not utilised. A low bed had been procured for one resident and crash mats and sensor alarms were

also used as alternatives. Policy on the use of methods of restraint and enablers was detailed and practices were found to be in line with the policy. An audit undertaken and reviewed by the inspector indicated that the use of bed rails and lap belts had reduced since January 2014 from 16 bed rails and two lab belts to 8 eight bed rails and one lab belt. The assessment for the use of the lab belt was thorough and clearly identified the symptom to be supported by its usage. There were also documented checks on the bed rails for safety reasons and documented hourly checks on residents overnight. The consultation process with relevant multidisciplinary services was evident in the assessment tool. Alternatives were explored and tried in the first instance. A register of such interventions was maintained.

However, a number of residents were prescribed psychotropic medication on a PRN (pro-re-nata) basis for the management of behaviours. A review of a sample of the administration charts indicated that on occasions these were used for consistent periods of time. In one instance such medication was administered for fifteen days at either full or partial dosage. A cross reference of the daily nursing records for the period did not state the reason this medication was required at the time. This was not reviewed to ensure the practice was not unreasonably restrictive or unnecessarily implemented.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

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

Theme:

Safe care and support

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

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

Findings:

There was a current and signed health and safety statement available. Systems for review of safety and risk were evident. A detailed safety audit of the premises and work practices had been undertaken. A health and safety committee meets on a quarterly basis with the last meeting having taken place on 12 August 2014 and this meeting identified actions, time frames and persons responsible for completing them. The risk management policy was in compliance with the regulations including the process for learning from and review of untoward events. This policy was further supported by relevant policies including an emergency plan. The emergency plan was detailed and it contained all of the required information including arrangements for the interim accommodation of residents should this be required. Access to a generator on a twenty four hour basis had been arranged. Emergency phone numbers were readily available to staff. Core safety features including flooring, hand-rails, working call-bells and coded exits and entrances were evident. Training records demonstrated that staff had undergone specific training in moving and transporting residents.

As required following the last inspection a detailed risk assessment of residents who smoked was undertaken and reviewed and this was added to the health and safety risk register. The smoking room was equipped with suitable extinguishers and a fire blanket and residents are easily visible in the room. In accordance with their risk assessment some residents do not have access to a lighter or matches and these precautions had as required been added to the health and safety risk register. A number of residents were assessed as requiring a fire retardant apron. However in some instances the residents were unable to cooperate with this requirement and this was documented. In order to ensure the residents safety and a prompt response in case of an accident the person in charge had allocated staff to be present either in or immediately outside the smoking room. This was observed by the inspector and residents also confirmed this action.

Actions required in relation to fire safety had been satisfactorily addressed. Fire safety training had taken place annually for all staff and this training included the use of the fire compartments, movement of residents and the use of ski sheets where these were indicated. Several training sessions, facilitated by a competent person had taken place between 2013 and 2014 to ensure all staff was included. Fire safety procedures were satisfactory with documentation confirming that the fire alarm and emergency lighting was serviced quarterly and other equipment serviced annually as required. Fire drills were held twice yearly. Daily checks on the exit doors and fire panel were recorded and the exits were unobstructed on the days of the inspection. A weekly alarm sound on the fire alarm was undertaken. The fire procedure was displayed and all staff spoken with were able to demonstrate a good knowledge of the procedure to be used in such an event. The statutory fire authority had undertaken a review of the premises in January 2014 and the report available indicated that no actions were required. Written evidence from a suitably qualified person of compliance with the statutory fire authority had been forwarded to the Authority with the application for registration.

The fire alarm was activated during the inspection. This was a false alarm in the boiler room. The inspector observed that staff acted according to the instructions and maintained residents within the safe zones. In the interests of safety and to ensure the zone identified was safe the staff requested the alarm company attended at the centre to deactivate the alarm. The external door releases had been activated and therefore the residents required close supervision and monitoring by staff. The staff acted to ensure residents remained safe within the premises but did so in a reassuring and calm manner until the situation was resolved.

A review of the accident and incident log logs demonstrated that accident such as falls were, as required following the previous inspection reviewed and additional supports implemented where this was required. These included additional staff supervision. A resident is individually supervised by staff until he falls asleep at night to help prevent a fall. Hip protectors are used and resident's footwear reviewed for safety. Policy on the prevention and control of infection was satisfactory and staff were knowledgeable on the procedures to be used on a daily basis and in the event of any specific concern. Appropriate protective equipment was seen to be available and used.

The inspector was satisfied that the safety of residents was prioritised but some improvements were required. Records showed that staff had received updated training in moving and transporting residents. While most plans in relation to the moving of residents gave precise instructions some did not state the number of persons required

for assistance or the type of hoist to be used. Good practice in moving and handling was observed. However, there were no directions for staff in relation to the safe use of the hoist and the correct slings to be used for individual residents. Staff were able to inform the inspector of the correct procedures however.

Despite the availability of the risk management policy some risks had not been adequately identified and supported with clear guidelines. For example, the missing person policy required review. It identified the need for preventative actions such as the security of the exit doors and these were implemented. However, it did not take the specific geographical area of the centre into account which could pose a risk to residents if actions were not taken in a timely manner. There was no risk register which would identify risks specific to the residents such as the location of the centre and safe use of equipment such as hoists for residents.

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:

Current policy on the management of medication was centre-specific and in line with legislation and guidelines. Systems for the receipt of, management, administration, storage and accounting for controlled drugs were satisfactory. There are appropriate documented procedures for the handling, disposal of and return of medication. Medication was reviewed three monthly or more often for individual residents where this was deemed necessary.

Records also demonstrated that staff observed residents response to medication and reported to the resident's general practitioner (GP) or relevant clinician and amendments made where required. An audit of medication administration, storage and recording practices was undertaken by the pharmacist and internally by the person in charge and any discrepancies were identified and acted upon. No medication errors had been reported at this time. At the time of this inspection no residents were deemed to have the capacity to self-administer medication. A pharmacist is contacted by the provider to dispense all modifications. Monitoring of the use of psychotropic medication this is actioned under Outcome 7 Safeguarding and Safety.

Judgment:

Compliant

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:

A review of the accident and incident logs, resident's record and notifications forwarded to the Authority demonstrated compliance with the obligation to forward the required notifications to the Authority. There was also evidence that any incidents or incidents were reviewed by the person in charge and included in the monthly auditing system.

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):

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

Findings:

There were 38 residents present in the centre at the time of this inspection. Admission processes included a full assessment undertaken by the person in charge prior to admission and it was apparent that the systems to ensure full information was available had been improved in terms of the detail required to support decision making. There was detailed transfer information available should a resident require admission to or from acute care services. From a review of eight care plans and medical records the inspector was satisfied that the healthcare requirements of residents were met to a good standard. Residents could, if geographically possible, retain their own GP service. In reality a local GP clinic provided healthcare for most residents. All residents had updated evidenced based assessment tools completed for pressure area care, falls, nutrition, and other needs specific to the residents. These assessment tools were reviewed three monthly or following any change in the resident's status. Records demonstrated that residents had access to allied services including speech and language, physiotherapy, occupational therapy and psychiatry of old age, chiropody, ophthalmic and dentistry. Physiotherapy was available for group and individual sessions. The recommended interventions of these disciplines were detailed in the

residents' records.

Care plans were found to be reviewed at a minimum four monthly and it was evident that this review was focused and noted any changes which had taken place for the resident. The care plans demonstrated a good knowledge of the individual residents in terms of healthcare. Weights food and fluid intake were monitored in accordance with the resident's condition and under the direction of the dieticians. Responses to changes were seen to be prompt. Protocol for the use of Percutaneous Endoscopic Feeding systems(PEG) was documented and staff could describe the procedures they used. Nursing staff had received training in the management of subcutaneous fluids in order to avoid unnecessary admissions to acute care services. Supportive aids were evident including walking frames and residents were individually supported to maintain their independence as their capacity allowed.

Nursing notes, maintained on a daily basis were reviewed by the inspector. These were detailed, correlated with the care plans and clearly outlined the care provided to residents. Consultation was not clearly documented on the care plans but relatives and those residents who could communicate with the inspector confirmed this occurred. Residents choices in regard to treatment were noted and respected. However , the care plans did not provide sufficient guidance for staff on the management of behaviour and residents social care needs.

Residents who could communicate with the inspector stated that they were very satisfied with the healthcare they received and that staff were prompt and attentive to them. Relatives also indicated via questionnaire and interview that they were kept fully informed of the care plans and any changes were quickly communicated to them.

The actions required following the previous inspection related to the adherence to the treatments plans as outlined by the tissue viability specialists. This action was satisfactorily implemented and treatment plans including regular photographing of the wounds and adherence to the guidance provided was evident. Preventative measures such as skin care regimes, dietary supplements and the use of pressure relieving equipment was evident in documentation and observed by the inspector. Two staff had undertaken wound care management in April of 2014. There was a policy on the prevention and management of wounds. However the policy was generic and did not provide specific guidelines for staff in wound management with particular reference to the time-frames for referral to specialists There was a significant delay noted in referring a resident to a wound care specialist for a significant pressure sore despite the evidence of lack of improvement. The inspector acknowledges that this wound did not originate in the centre.

Judgment:

Non Compliant - Moderate

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

Theme:

Effective care and support

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

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

Findings:

Overall the premises were fit for its stated purpose with some improvements required. It was a single story structure, divided into three sections and comprised of a dining room, large sitting room, conservatory and dedicated smoking room. Bedroom accommodation was comprised of 10 single rooms, 11 twin-bedded rooms and two multi occupancy rooms of three residents. Six of the single rooms had en suite shower and toilet facilities. There were two multi-occupancy bedrooms, one of which contained a toilet en suite. One of these multi-occupancy rooms had previously accommodated four residents which was reduced by the provider to three following the previous inspection. Bedrooms had locking mechanisms which can if necessary be opened by staff. While there was ample space in the bedrooms for the storage of clothing and possessions there was no facility to lock away personal items regardless of the residents capacity to do so.

There were two assisted showers and one bathroom. However the latter was not utilised as it was not suitable for residents who required assistance and was equipped as the hairdressing room. This does not meet the standard requirements for one shower or bathroom for eleven residents when the en suites are taken into consideration. Therefore the number of facilities available to the residents was not sufficient. There was a sufficient number of toilets (four) three of which are suitable for wheelchair use.

Some improvements were required in terms of upgrading of the toilet facilities and general paintwork in the hallways. Visitors and staff share a toilet. There was a functioning call bell system in place.

The bedrooms were spacious and personalised and there was room for chairs, furnishing and any assistive equipment required. There was an adequately equipped sluice facility. Staff toilets including facilities for catering staff were available. Storage for equipment was limited however and resulted in equipment such as hoists and large chairs being stored in the shower room and in an overcrowded store room.

Records reviewed by the inspector demonstrated that all equipment for residents use and comfort was serviced annually or more frequently including specialist's beds, chairs, call-bells and heating systems. Safe flooring and grab rails were available in all areas. Access to and from the premises was secured via code. There is dedicated maintenance person assigned to the centre. A maintenance log is maintained and any issues appeared to be dealt with in a timely manner. A suitable safe garden was available and easily accessible to residents which contained appropriate seating and planting.

The provider had submitted a satisfactory plan to the Authority for the reduction of the

three bedded multi-occupancy rooms in order to address the requirements of the Regulations Standards within the time frame of June 2015. This includes the reduction of one such room to a two bedded room and the redesign of the second room to allow one full single and a double room of suitable size.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

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

Findings:

There were written operational policies and procedures for the making and management of complaints. The policy included the function of the designated person who is responsible for overseeing and monitoring the implementation of the complaints procedures in accordance with Regulation 34 (3). The process of local resolution of complaints was undertaken by the person in charge. The sample of complaints viewed by the inspector indicated a willingness to address any issue raised. They were resolved satisfactorily and promptly and the complainants views of the outcome were ascertained. Adequate records were maintained. Residents and relatives spoken with indicated that they were aware of how to make a complaint and felt confident in doing so.

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:

There was a written operational policy on end of life care. A number of staff had recent training in supporting residents and ascertaining resident's wishes in relation to this. The

self assessment on end of life care completed by the person in charge identified that this training would be provided to an additional number of staff. Records reviewed indicated that there was advanced planning, in terms of treatment options, admission to acute care services or palliative support. This was undertaken in consultation between the medical personnel, families and the resident where this was possible and this was documented.

A review of a sample of records demonstrated that resident's comfort, support and pain symptom management was prioritised by staff at this time. Relatives were accommodated to remain on the premises and food and refreshment was provided. Religious affiliations were supported generally with regular access to ministers and this was prioritised at the time of death. There were appropriate religious symbols and all legal requirements including verification of death and reporting to the coroner's office were documented. Records were detailed and complete. There was evidence of good access, liaison and support with palliative care services if required and staff had training in cardio pulmonary resuscitation.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Relevant policies and guidelines were in place to support nutritional intake and hydration. There was evidence on records available of the consistent monitoring of residents nutritional status and there were effective systems in place for monitoring resident's nutritional needs. The malnutrition universal screening tool (MUST) was undertaken within twenty four hours of admission and repeated to identify any resident at risk. Weights are monitored either weekly or monthly as dictated by the residents needs. There was evidence of referral to dieticians and speech and language therapist for all those residents on either modified or altered consistency diets. There was a documentary system for communicating specific dietary requirements between the catering staff and nursing staff. Staff were found to be knowledgeable on these dietary requirements and the correct fluid consistencies prescribed for residents. As observed by the inspector the resident meals were consistent with the directions of the clinicians.

Residents, including those on modified foods, were offered a choice at all meals and the menu was seen to be varied and reviewed by the dietician who is employed by the

provider. Meals observed including modified meals, were presented in an appetising manner. Snacks and hot and cold drinks including juices, fresh drinking water and soup were readily available throughout the day. Food was available for late suppers and those residents on puréed diets were provided with foods such as rice, custard and soft fruits. Food such as sandwiches, fruit and yoghurt were available for snacks at different times of the day.

A food safety management plan was in place and the most recent environmental health officers report was also available. A number of minor actions had been identified and the inspector was informed that these had been remedied. Catering staff had completed the required food safety training and had also received nutritional training from the dietician. Residents were provided with additional supplements as deemed necessary and prescribed by the medical officer. The inspector observed that there was sufficient staff to ensure residents were supported in an unhurried manner with staff observed to be communicating and encouraging residents. Mealtimes were held in two sittings. This was to accommodate the number of residents but also to cater to residents preferences and need for assistance. For example, one resident liked to sit alone at the table when having meals and this was accommodated. Breakfast was staged according to the resident's preferences and was seen to continue late into the morning with some having it in the comfort of their dressing gowns.

The inspector noted that there was no assistive crockery or cutlery used which would support some residents to remain independent. This was discussed at the feedback meeting with the person in charge who agreed to review the matter.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:
Person-centred care and support

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

Findings:
Residents who could communicate with the inspector were able to articulate their medical and care needs and indicated that they were consulted in regard to their care. Written feedback from relatives also indicated that they were consulted regarding care plans and care needs. It was apparent that there was choice in regard to their daily routines such as getting up or attending activities. Feedback and consultation processes

took account of the dependency levels and capacity of the residents. For this reason a residents forum does not take place but a dedicated advocate meets with residents and or relatives in small groups on circa a monthly basis. A review of the records maintained by the advocate indicated that a number of avenues were explored including food preferences and these were acted upon. For example, changes were made to the menus, and additional care staff was allocated duty in one section until 22:00hrs at night. The provider had agreed terms of reference for the advocate which included confidentiality.

The inspector also observed that the person in charge was very visible throughout the day and staff consulted consistently with the residents during the inspection in relation to what they wished to do or where they wished to sit. Relative surveys had been undertaken in 2014 and overall the outcome was positive. A support group for relatives of resident with dementia was also held occasionally outside of the centre. Newspaper and other media such as television were evident and voting arrangements were made when required.

Visiting times were flexible as observed and staff were observed respecting residents' privacy in their style of communication with them. The inspector noted that staff communicated gently and in an unhurried and respectful manner with residents, knocked on doors before entering and closed doors when undertaking personal care. Staff also demonstrated a knowledge of the individual resident's means of expression and were able to interpret the meaning and act to address resident needs. Religious affiliations were well facilitated. While CCTV cameras are used for security purposes externally they are not used internally.

A significant number of residents had cognitive impairment and communication difficulties and in some instances sight problems. Some care plans held details on the residents communication needs and staffs were able to outline strategies such as showing residents samples of food to elicit their preference. A resident was moved to another room as the light was better in response to deteriorating eyesight. These strategies were limited however and overall the care plans and strategies had not been developed to promote this aspect of care practice sufficiently taking the residents assessed needs into account. Appropriate signage for example was not used to promote memory and guide residents in their daily lives. There is currently no dedicated activities coordinator. Organised activities such as music are undertaken twice weekly by external persons. Care assistant staff undertook a range of activities such as nail painting with the residents. Individual residents are supported to walk in the garden or outside the centre with staff and a number of group outings were organised including trips to the coast. On occasions residents who were able took part in the local community pilgrimage to Lourdes. Appropriate DVDs were played according to residents preferences. They were informed of the activities and could participate or not as they wished and could remain in their rooms if they wished. However, given the significant number of residents with cognitive impairment and behaviour that challenges this aspect of the care programme requires further development to ensure all residents are supported to participate in accordance with their capacities. Two of the care assistant staff has been trained in Sonas therapeutic intervention but it is not utilised.

It was observed that that conservatory is not used consistently. All activities and relaxation is focused primarily on the large day room which means that all residents are combined for significant periods of time regardless of the impact of behaviours on other residents or the activity taking place.

Judgment:

Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy on the management of residents clothing and possessions. There was a documented and current record of residents personal possessions maintained. Valuables held for safe keeping were recorded and the signatures of staff and residents where this was possible was evident. Residents clothing was laundered on the premises. The inspector noted that many items of clothing were not labelled and a resident and relative also stated that on occasions the clothing is not returned to the correct owner.

Judgment:

Non Compliant - Moderate

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 inspector reviewed the actual and planned staff roster and from observation was satisfied that there was a sufficient number and suitable skill mix of staff on duty to meet the needs of residents during the day. There were two nurses on duty from 8:00hrs until 20:00hrs each day including weekends with between 6 and four care assistant staff until 20:00hrs. A care assistant staff works a twilight duty from 19:00hrs until 22:00hrs. Fifteen residents have been assessed as maximum dependency with 10 as high dependency. The nursing staff ratio overnight was therefore one nurse to 37 residents. The inspector acknowledges that there is no direct evidence to indicate that this has impacted on residents care. This finding was discussed this with the operations manager at the inspection. He stated that in order to satisfactorily review the skill mix the person in charge would undertake a number of visits to the centre at night time to ascertain the suitability of the staffing arrangements given the dependency level and assessed needs of the residents.

On-call is available in the person in charge and assistant director of nursing and the person in charge of other centres managed by the organisation. There was sufficient catering and household staff available who were knowledgeable on their respective responsibilities and duties. Adequate arrangements were in place for holiday and emergency cover.

A sample audit of three personnel files demonstrated that the provider had sourced the required documentation, including An Garda Síochána vetting, proof of identification, the required number of references and evidence of qualifications. Current registration numbers for all professional staff were available. Some gaps in relation to the information required regarding employment history were evident and these are action under Outcome 4 Records and Documentation. As required following the previous inspection agreed terms and evidence of insurance and vetting for outsourced staff was available. Volunteers who undertook specific activities with the group of residents were appropriately supervised.

Examination of the training matrix demonstrated mandatory training in fire safety and manual handling was up to date and elder abuse training had also been undertaken. In order to comply with the actions outlined by the previous inspection report three nurses had undergone training in wound care management in April 2014. Other training of relevance and undertaken at regular intervals included end of life care for 20 staff in March 2014, and one staff had undertaken training in palliative care. Management of challenging behaviours had taken place in February 2014 for six staff and further training in dementia and challenging behaviours was scheduled for 22 August 2014. This was in recognition of the needs of the residents. Records demonstrated that 13 of the care assistant staff were qualified to Further Education and Training Awards Council (FETAC) level five with one staff to level six.

There was a detailed induction plan in place for staff of various roles to ensure they were familiar with the procedures and with residents care needs. This included a number of days supernumerary time. Three and six monthly probationary periods were undertaken and recorded. The person in charge had commenced a process of regular

meetings with staff of various grades. Supervisory responsibilities were allocated with specific staff assigned for this function. Records of the team meetings held showed that the focus was on resident care and changes to work practices to bring about improvements for residents. The person in charge stated that she intends to further develop these meetings. Inspectors found that staff were aware of the policies and procedures, Regulations and Standards and staff articulated their various roles competently.

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:

Noelene Dowling
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:	The Croft Nursing Home
Centre ID:	OSV-0000028
Date of inspection:	20/08/2014
Date of response:	18/09/2014

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 03: Information for residents

Theme:

Governance, Leadership and Management

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

The details of all fees are not clearly outlined in the contract.

Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

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

Silver stream Healthcare will be issuing new Contracts of Care, which will include a detailed description and breakdown of the additional charges.

Proposed Timescale: 31/10/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Records pertaining to staff did not contain all of the information required by Schedule 2.

Action Required:

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

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

The Director of Nursing and the HR manager has completed a comprehensive audit of all staff files.

All files are fully compliant with regulation 21(1) under schedule 2, 3, and 4.

Proposed Timescale: 31/10/2014

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:

Residents records pertaining to the ongoing usage of Pro-re-nata medication to manage behaviour did not detail the reason the medication was being administered.

Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

Director of Nursing will complete a full review of all residents in the home who are currently prescribed psychotropic and Prn medication. This review will be conducted through the forum of a clinical forum meeting, comprising of the Director of Nursing, Assistant of Nursing, Staff Nurses, Healthcare worker, General Practitioner, and

Pharmacist.

The review will specifically focus on the use of Prn medication within the home, identifying its purpose whether its use is for pain management / reduction of anxiety /restraint etc. When Prn medication is prescribed and offered to a resident, the nurse must use his/her clinical judgement for such intervention. The evidence of her clinical judgement shall be documented in the daily nursing notes and in the Mars medication record and also behavioural charts where required.

Proposed Timescale: 25/08/2014

Theme:

Safe care and support

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

In some instances practises in relation to the administration of pre-re-nata medication to manage behaviour and as a means of restraint was not reviewed in accordance with national policy.

Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

The Director of Nursing should ensure that all staff are aware of and comply with all policies, procedures and guidelines, and that staff have undertaken appropriate training.

The Director of Nursing will review and audit processes to evaluate the use of medication as a form of restraint in relation to the principles of the National Policy. This can be achieved through the monthly audit review which is held with each nurse individually.

Proposed Timescale: 30/09/2014

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:

The implementation of the risk management policy and supporting missing person policy did not adequately account for the location of the centre in the event of a resident going absent.

Action Required:

Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management

policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

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

The risk assessment policy has been amended under the missing persons section, taking cognisance of potential dangers in the immediate vicinity of the home.

Proposed Timescale: 30/10/2014

Theme:

Safe care and support

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

The risk management policy was not sufficiently detailed to ensure staff were provided with and implemented the correct procedures for the safe use of the hoist.

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:

The risk management policy will be amended to detail the correct safe use of the hoist. All staff within the home will be briefed on the amended risk policy, each staff member will have to demonstrate correct safe use of the hoist with the Director/Assistant Director in line with the policy. The evidence of this will be recorded in their personal file.

Proposed Timescale: 17/10/2014

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Residents did not have care plans which detailed their social and behavioural care needs.

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:

The Director of Nursing has scheduled care planning training which is delivered in the Silverstream head office as part of the group's response to effective care planning for

the older person in the residential care environment.

This programme focuses specifically at addressing resident physical, psychological and social care needs using a person centred approach.

Proposed Timescale: 31/10/2014

Theme:

Effective care and support

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

Referrals to allied health specialists was not at all times prompt.

Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

The Director of Nursing or the Assistant Director of Nursing following the Daily Report will review any residents whose care is of concern.

The resident will be referred to the G.P. and following his assessment and consultation, a referral can be made to allied health specialists such as the tissue viability nurse or the dietician.

Proposed Timescale: 16/09/2014

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The multi occupancy rooms do not meet the requirements of the regulations and the Authority' s Standards for 2015.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

The Statement of Purpose has been amended to reflect the number of rooms in the home.

The plans which were submitted to the Authority for the reduction of the three bedded multi-occupancy rooms will address the matters set out in Schedule 6.

Proposed Timescale: 30/06/2015

Theme:

Effective care and support

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

There was an insufficient number of baths and showers available for residents use.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

The old bathroom will be reconstructed as a shower room.

Proposed Timescale: 31/10/2014

Theme:

Effective care and support

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

Residents did not have lockable storage space for personal possessions.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

All residents have lockable storage space in the Centre.

Proposed Timescale: 25/08/2014

Theme:

Effective care and support

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

There was insufficient storage space for equipment in the centre.

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

A comprehensive review of all storage space is being carried out, non essential equipment to be stored off site.

Proposed Timescale: 31/10/2014

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:

Activities for residents did not take account of the individual needs or cognitive status of the residents.

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:

A comprehensive dementia review strategy has been initiated within the home. This will identify the cognitive needs of each resident and the effective deployment of staff to meet this need. We are also in the process of employing a full time activity co coordinator who has a recognised dementia care qualification.

Proposed Timescale: 30/12/2014

Theme:

Person-centred care and support

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

Strategies for supporting residents who had communication difficulties were not detailed and implemented.

Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

The Director of Nursing will ensure that residents communication patterns and needs are identified and addressed, and the care plan will be commenced within 48 hrs. of admission.

Liaise with the resident and representative to identify communication needs and plan accordingly.

The residents care plan will be communicated to all healthcare staff involved in the residents care.

The Director of Nursing will re commence Sonas Therapy in the home with the trained

staff.

Training in Dementia Care will be organized for all staff.

Proposed Timescale: 30/12/2014

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:

Systems to ensure that residents clothing is returned to the correct resident were not robust.

Action Required:

Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

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

An audit will be carried out to ensure that resident's clothes are clearly marked and returned to the correct resident.

Proposed Timescale: 30/09/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The skill mix of staff at night time had not been reviewed to ensure that it was suitable to the assessed needs of the residents.

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:

We are comfortable that the skill mix at night is more than adequate to meet the needs of our resident group. We assess the dependency levels of the home monthly and have the flexibility to adjust our staff to meet their needs.

We placed an extra night staff member from 6-10 to support night staff, however the Director of Nursing and the Assistant Director of Nursing will roster themselves for a night duty to establish practice.

Proposed Timescale: 31/10/2014

