

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Waterford Nursing Home
Centre ID:	OSV-0000255
Centre address:	Ballinakill Downs, Dunmore Road, Waterford.
Telephone number:	051 820 233
Email address:	waterfordnursinghome@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Services
Provider Nominee:	Pat Shanahan
Lead inspector:	Kieran Murphy
Support inspector(s):	Ide Batan
Type of inspection	Unannounced
Number of residents on the date of inspection:	58
Number of vacancies on the date of inspection:	2

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, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 17 November 2015 06:00 To: 17 November 2015 14:30

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

Outcome	Our Judgment
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Major
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a one day unannounced inspection of Waterford nursing home. The Authority had received two separate concerns in relation to potential issues of safeguarding vulnerable adults in the centre:

- The first concern related to an allegation of institutional practice whereby residents were being washed and dressed before day staff began duty at 08:00. The concern also included information that residents who received night sedation were being woken early in the morning.
- The second concern related to the removal of a call bell from a resident at night. A call bell is an alarm system so that a resident can get immediate attention if needed. The call bell also acts as a way to reassure residents that assistance is always close at hand.

The person in charge outlined to inspectors that he had been made aware of a complaint regarding an allegation of neglect of a resident. Inspectors spoke to staff regarding this allegation of neglect. The person in charge said that he was to conduct an investigation into this allegation which he was to forward to the Authority.

Of the six outcomes that were reviewed on this inspection, four were at the level of major non-compliance:

Outcome 7: safeguarding and safety

Inspectors found evidence to uphold the first concern relating to institutional practices. After inspectors arrived at the centre, by 06:05 there were two residents awake and dressed and sitting in the dayroom, one resident upstairs and the second resident downstairs. By 06:30 two further residents were dressed and sitting in the dayroom, while a fifth resident was being washed and dressed at that time. Cleaning staff were observed by inspectors at 06.30 to be washing and polishing the floors with a machine. At that time of the morning this machine could be heard throughout the ground floor. Inspectors also saw evidence of the "communication carers books". These books were used by healthcare assistants to record on a daily basis which residents were washed and dressed by night staff.

In relation to the second concern of removing call bells from residents at night inspectors found that investigation process into this allegation was not comprehensive or completed within a reasonable time frame. There was evidence that staff had reported this issue of removal of call bells from residents on 27 August 2015. The person in charge had completed a report of his investigation into the disconnection of call bells. While the substantive issue of unplugging call bells had been addressed by the introduction of a new call bell system, the issue of staff unplugging call bells in an unauthorised manner had not been adequately investigated. Inspectors were given a draft copy of a separate investigation in relation to the unplugging of call bells being undertaken by Mowlam Healthcare as part of a human resource process. The nominee on behalf of Mowlam Healthcare indicated that this process would be completed within four weeks.

Outcome 8: risk management

While this inspection was focused on safeguarding of residents, risk assessments as they related to the safeguarding of residents were also examined. It was found that improvement was required as to how risk assessments were being undertaken, communicated to staff and followed by staff.

Outcome 9: medication

Inspectors reviewed a sample of prescription and administration records as information received by the Authority indicated that residents who received night sedation were woken early in the mornings. On the morning of 17 November 2015 inspectors observed that four residents who were up in the morning before 06:30hrs had received night sedation the previous night. One resident had received two different types of psychotropic medication the previous night. Inspectors saw that this resident was washed, dressed and sitting in the dayroom at 06:10hrs.

Inspectors noted that a medication administration record indicated that a resident received a dose that was 50% higher than the dose clearly prescribed on the medication prescription sheet. Inspectors were not assured that nursing staff were administering medications from the prescription records as this error would not have occurred if nursing staff had administered medication from the prescription which clearly indicated that the medication dose had been altered.

Outcome 10: notifications of incidents

An incident of an allegation, suspected or confirmed of abuse of a resident had

occurred on 29 August 2015. Inspectors saw evidence that the incident had been verbally reported by staff to the assistant director of nursing on the morning after the incident. In addition, staff had provided written statements when requested by the assistant director of nursing. However, the Authority had only received a notification from the person in charge on 30 October 2015.

Outcome 11: Health and Social Care Needs

The person in charge outlined to inspectors that he had been made aware of a complaint regarding an allegation of poor wound care regarding a resident. Inspectors reviewed care plans and turning charts for a resident with pressure sores. Inspectors also spoke to staff regarding this allegation of neglect. Based on this initial review of care inspectors were not satisfied that wound care management was in accordance with evidence based practice.

Inspectors saw that a referral had been made to a palliative care service which indicated that symptom control was adequate. However, there was no evidence of an integrated multidisciplinary approach to care which would ensure that all complex pathways in relation to physical decline of residents is evident and based on contemporary evidence based practice. The person in charge said that he was to conduct an investigation into this allegation which he was to forward to the Authority.

In relation to other non-compliance, during the course of the inspection personal information regarding residents such as personal care needs were left in day rooms which were accessible to all residents and visitors. Inspectors were not assured that staff used discretion when communicating personal care needs either as inspectors saw all this information with residents' names present in communication books used by care staff.

Overall inspectors concluded that there were shortcomings in clinical leadership as evidenced through the deficits outlined in the report. Inspection findings including non-compliances are discussed in the body of the report and in the action plan at the end of the report.

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

***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:

Information governance required significant improvement.

Inspectors saw that personal information regarding residents such as personal care needs were left in day rooms which were accessible to all residents and visitors. Inspectors were not assured that staff used discretion when communicating personal care needs either as inspectors saw all this information with residents' names present in communication books used by care staff.

Judgment:

Non Compliant - Moderate

***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:

The Authority had received two separate concerns in relation to potential issues of safeguarding vulnerable adults in the centre:

- The first concern related to the practice of night staff waking residents and getting people washed and ready before the day staff came on duty at 08:00.
- The second concern related to the removal of a call bell from a resident at night. A call bell is an alarm system so that a resident can get immediate attention if needed. The call bell also acts as a way to reassure residents that assistance is always close at hand.

Inspectors found evidence to uphold the first concern relating to institutional practices. In relation to the second concern inspectors were not satisfied that an adequate investigation had taken place into the issue of staff disconnecting the call bell. Based on the inadequate response to this allegation, inspectors were not satisfied that the provider and the person in charge took all reasonable measures to meet their legal obligations and ensure the protection of residents.

The first concern related to an allegation of institutional practices whereby residents were being washed and dressed before day staff began duty at 08:00. After inspectors arrived at the centre, by 06:05 there were two residents awake and dressed and sitting in the dayroom, one resident upstairs and the second resident downstairs. By 06:30 two further residents were dressed and sitting in the dayroom, while a fifth resident was being washed and dressed at that time. At various points during the morning one of these residents was observed by inspectors to be asleep in the armchair in the dayroom.

Night staff reported to inspectors that too many people were being gotten up early. Night staff said they were asked to wash and dress residents early to assist the day staff who were coming in at 08:00. The person in charge stated to inspectors that this issue of residents being gotten up early had been brought to his attention but that it hadn't been formally brought to a conclusion as yet.

Cleaning staff were observed by inspectors at 06.30 to be washing and polishing the floors with a machine. At that time of the morning this machine could be heard throughout the ground floor. When asked staff said this was the usual time that the floors were washed and polished.

Inspectors reviewed the "communication carers books". These books were used by healthcare assistants to record on a daily basis which residents were washed and dressed by night staff. Of the sample of 19 days reviewed, on average six residents (four people upstairs and two downstairs) were washed and dressed by night staff before 08:00. The "communication carers books" also contained a "shower list" for residents on each floor. The "shower list" outlined which residents were to receive a shower each day of the week. Staff outlined that they recorded which residents had received a shower on the electronic recording system. However, when inspectors sought confirmation that a particular resident had received a shower on a weekly basis, the last record on the electronic recording system was for 2 November 2015. There was no record of this resident receiving a shower in the two weeks since that date. The use of these "communication carers books" and the allocation of set days to residents for

showering could be described as institutional practices.

The second concern related to the removal of a call bell from a resident at night. If the call bell was removed a resident could not request assistance from staff. Inspectors saw evidence that incidents of potential abuse of vulnerable adults were being reported by staff to their immediate line manager as per the centre's policies. There were policies and procedures in place for the prevention, detection and response to abuse. There was also a policy, called the whistleblower policy, which staff could also use to identify concerns. The policy on responding to allegations of abuse outlined that: "any staff member who receives information, suspects or is concerned that a resident has or is being abused or is at risk of being abused has a duty of care to report the matter as soon as possible to his/her immediate line manager." The whistleblower's policy outlined that: "where staff identifies an issue of concern they shall be encouraged to report it to their line manager or director of nursing."

In particular inspectors saw evidence that the issue of removal of the call bell had been verbally reported by staff to the assistant director of nursing on the morning after the incident. In addition, staff had provided written statements when requested by the assistant director of nursing in relation to the removal of the call bell. However, inspectors were not satisfied that an adequate investigation into this issue had been completed. The person in charge had completed a report of his investigation into the disconnection of the call bell. While the substantive issue of unplugging the call bell had been addressed by the introduction of a new call bell system, the issue of staff unplugging the call bell in an unauthorised manner had not been adequately investigated. The provider nominee on behalf of Mowlam Healthcare outlined to inspectors that the new system involved the resident call bell now rings on the telephone system throughout the centre and a member of staff is allocated to respond to it.

Inspectors were given a draft copy of a separate investigation in relation to the unplugging of call bells being undertaken by Mowlam Healthcare as part of a human resource process. The nominee on behalf of Mowlam Healthcare indicated that this process would be completed within four weeks.

Judgment:

Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

While this inspection was focused on safeguarding of residents, risk assessments as they related to the safeguarding of residents were also examined. It was found that improvement was required as to how risk assessments were being undertaken, communicated to staff and followed by staff.

There was a risk assessment, dated 18 June 2015, related to the hazard of "a resident being struck by another resident for continually ringing the bell". However, there was evidence that staff were not aware of this risk assessment and that, consequently, this risk assessment was not being followed by staff. The person in charge told inspectors that healthcare assistants and some nursing staff did not understand the concept of risk assessment.

Judgment:

Non Compliant - Major

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:

Inspectors reviewed a sample of prescription and administration records as information received by the Authority indicated that residents who received night sedation were woken early in the mornings. On the morning of 17 November 2015 inspectors observed that four residents who were up in the morning before 06:30hrs had received night sedation the previous night. One resident had received two different types of psychotropic medication the previous night. Inspectors saw that this resident was washed, dressed and sitting in the dayroom at 06:10hrs.

Inspectors observed that medicines to be administered to residents were not equivalent to those prescribed. Inspectors noted that a medication administration record indicated that a resident received a dose that was 50% higher than the dose clearly prescribed on the medication prescription sheet. The inspectors observed that the resident was asleep throughout the morning in a chair in the dayroom. Inspectors were not assured that nursing staff were administering medications from the prescription records as this error would not have occurred if nursing staff had administered medication from the prescription which clearly indicated that the medication dose had been altered.

Therefore inspectors concluded that nursing staff were administering medication from the administration records which is not in accordance with best practice in medication management.

Judgment:

Non Compliant - Major

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:

It is a requirement of the regulations that all serious adverse incidents are reported to the Authority within three working days.

An incident of an allegation, suspected or confirmed of abuse of a resident had occurred on 26 August 2015. Inspectors saw evidence that the incident had been verbally reported by staff to the assistant director of nursing on the morning after the incident. In addition, staff had provided written statements when requested by the assistant director of nursing. However, the Authority had only received a notification from the person in charge on 30 October 2015.

Judgment:

Non Compliant - Major

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):

This was the centre's first inspection by the Authority.

Findings:

Only the component of wound care was considered as part of this inspection.

The person in charge outlined to inspectors that he had been made aware of a complaint regarding an allegation of poor wound care regarding a resident. Inspectors reviewed care plans and turning charts for a resident with pressure sores. Inspectors also spoke to staff regarding this allegation of neglect. Based on this initial review of care inspectors were not satisfied that wound care management was in accordance with evidence based practice.

Inspectors saw that a referral had been made to a palliative care service which indicated that symptom control was adequate. However, there was no evidence of an integrated multidisciplinary approach to care which would ensure that all complex pathways in relation to physical decline of residents is evident and based on contemporary evidence based practice. The person in charge said that he was to conduct an investigation into this allegation which he was to forward to the Authority.

Based on the information reviewed inspectors formed the judgement that this outcome was a moderate non compliance as the person in charge had not completed the investigation.

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:

Kieran Murphy
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:	Waterford Nursing Home
Centre ID:	OSV-0000255
Date of inspection:	17/11/2015
Date of response:	08/12/2015

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 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:

Inspectors saw that personal information regarding residents such as personal care needs were left in day rooms which were accessible to all residents and visitors. Inspectors were not assured that staff used discretion when communicating personal care needs either as inspectors saw all this information with residents' names present in communication books used by care staff.

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

1. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

The practice of documenting in communications diaries in the centre has been discontinued. All staff are now aware that communication regarding the personal care of residents is discussed at staff handovers and documented on the electronic resident record. The description of care needs is documented on an individual basis on the care plan.

Proposed Timescale: 14/12/2015

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:

Incidents or allegations of abuse were not being adequately investigated by the person in charge.

2. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

In August 2015, a staff member made a comment to the Assistant Director of Nursing regarding his perception of an incident that occurred on night duty on the morning after the shift ended. The ADON failed to realise that he was attempting to report his suspicion of abuse until a later date when it was discussed again. At that point, a full preliminary screening process, including appropriate notification of the suspicion, was conducted by the PIC in accordance with the centre's policy on responding to suspicions or allegations of abuse. The outcome of the preliminary screening was that abuse did not occur. The staff member was reassured that no abuse had taken place. The ADON is now aware of ensuring that all reports of this nature must be escalated to the PIC and investigated thoroughly.

Proposed Timescale: 14/12/2015

Theme:

Safe care and support

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

There was evidence of institutional practices.

3. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

Of the residents who got up and dressed early on the morning of the inspection, three have a diagnosis of dementia. Two of the residents were found to be heavily soiled due to incontinence. They chose to get up after their hygiene needs were attended to. One was awake and was indicating that she wished to get out of bed, which she was assisted to do by the attending carers. They had been prescribed regular psychotropic medications, sometimes in the morning as well as at night and it is not unusual for them to get up early and they usually indicate their preference to do so as soon as they wake in the morning.

Two of the residents who arose early on the morning of the inspection do not have a cognitive deficit. One got up independently, and one requested assistance to get up. Staff are aware that the resident regularly has interrupted sleep and that she prefers to get out of bed when she wakes, even after short spells of sleep.

All staff have been reminded of the ethos of person-centred care and respecting residents' choices in the centre. The PIC and ADON will monitor this practice closely and they have encouraged staff to ensure that only those residents who express a preference to get up early are assisted to do so.

The start time for cleaning staff has been changed to 8.00am with immediate effect, which will eradicate early morning noise caused by their cleaning/polishing machines and equipment.

Proposed Timescale: 14/12/2015

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:

It was found that improvement was required how risk assessments were being undertaken, communicated to staff and followed by staff.

4. Action Required:

Under Regulation 26(1)(b) 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 risks identified.

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

Staff are aware of the need to assess and review risks associated with residents' physical or cognitive needs on an individual basis. The PIC will ensure that risk

assessments are completed appropriately and that all identified risks are also documented in the care plan, along with a description of the care and interventions required to reduce the risk of harm to each resident. This practice will ensure that all staff have immediate access to the complete plan of care of each resident on the electronic resident record, and this will include any specific interventions that may be unique to an individual resident.

Proposed Timescale: 31/12/2015

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:

Nursing staff were administering medication from the administration records.

5. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

All staff nurses will undergo a medication competency assessment to ensure that they are fully aware of their responsibilities and scope of practice in relation to safe administration of medicines. The PIC will monitor compliance with this and regular audits will be conducted to measure compliance.

Proposed Timescale: 31/12/2015

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

An incident of an allegation, suspected or confirmed of abuse of a resident had occurred on 26 August 2015. Inspectors saw evidence that the incident had been verbally reported by staff to the assistant director of nursing on the morning after the incident. In addition, staff had provided written statements when requested by the assistant director of nursing. However, the Authority had only received a notification from the person in charge on 30 October 2015.

6. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

The suspicion of abuse had been reported to the ADON on 27th August 2015, but the ADON was not clear that the nurse was reporting to her a suspicion of abuse and she failed to escalate this concern to the PIC. She believed that the nurse reporting to her was unaware of the systems that were already in place to protect the resident. She now realises that she should have reported his concerns at the earliest convenience to the PIC. The concern only became known at a later time when the PIC was investigating another issue. At this point, the PIC responded to the suspicion of abuse in accordance with the procedures outlined in the centre's policy. The ADON has learned the importance of a prompt intervention when a concern is raised. Further education on adult protection will be provided in the centre and the ADON will attend this learning opportunity to further her own knowledge.

Proposed Timescale: 31/01/2015

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:

Inspectors were not satisfied that wound care management was in accordance with contemporary evidence based practice.

7. 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:

The PIC has reviewed the care and management of residents with wounds in the centre. He has allayed the anxieties of staff regarding the prioritisation of care for a resident whose end of life was imminent. Advice was provided from the Palliative Care Team in respect of this resident also, in relation to frequency of turns and careful positioning to ensure that respiratory function was not further compromised and that pain and discomfort was not induced.

Wound care and palliative care education will be provided in the centre to ensure that the knowledge base of the staff is in accordance with contemporary evidence based practice.

Proposed Timescale: 28/02/2016