

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Powdermill Nursing Home & Care Centre
Centre ID:	OSV-0004456
Centre address:	Gunpowdermills, Ballincollig, Cork.
Telephone number:	021 487 1184
Email address:	personincharge.powdermill@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	JCP Powdermill Care Centre Limited
Provider Nominee:	Joseph Peters
Lead inspector:	John Greaney
Support inspector(s):	Mary O'Mahony
Type of inspection	Unannounced
Number of residents on the date of inspection:	38
Number of vacancies on the date of inspection:	1

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.

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 May 2017 11:00	22 May 2017 19:00
23 May 2017 08:20	23 May 2017 18:50

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

Powdermill Nursing Home and Care Centre is located close to the town of Ballincollig, which is approximately nine kilometres west of Cork city. It is a three storey premises, however, all resident accommodation is on the ground and first floors.

This inspection was a monitoring inspection, it was unannounced, took place over two days and was the 3rd inspection undertaken by HIQA of Powdermill Nursing Home and Care Centre in the past 12 months. The inspection was carried out in order to monitor continuing compliance with regulations and standards. As part of the inspection, inspectors met with residents, relatives, the provider, person in charge, clinical nurse manager, the operations manager, and staff members. Inspectors observed practices and reviewed documentation such as residents records, incident records, staff training records, and staff files.

While there was evidence of good quality of life for some residents living in the centre, overall, inspectors were not satisfied that there was an adequate level of

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.

Routines and practices supported residents to maintain their independence. Residents were supported to go to bed and get up in the morning at a time of their choosing. Residents that chose to have breakfast in their rooms were facilitated to do so and some residents were seen to have their breakfast in the dining room at various times throughout the morning. Some residents were seen to make cups of tea/coffee for themselves whenever they wished. Residents were encouraged to maintain their independence in relation to mobility and a number of residents were seen to move freely around the centre with the assistance of mobility aids. There was a good programme of activities and residents were seen to participate in activities enthusiastically.

Significant improvements, however, were required in relation to governance and management systems to ensure that residents were at all times safe. For example, an investigation conducted into the unexplained bruising of a resident, that is presumed to have occurred as a result of a fall, was not sufficiently comprehensive. The investigation report did not identify gaps in care that were immediately identified by inspectors from a review of documentation. Following a fall by a resident, inspectors were not satisfied that, at all times, adequate measures were put in place to minimise the risk of further falls. Notifications were not always submitted as required in relation to residents that required medical attention following an incident, in relation to the unexpected death of a resident, or in relation to the proposed absence of the person in charge. At least one notification contained inaccurate information.

Inspectors were not satisfied that staff were always supervised relevant to their role and abilities. While performance improvement plans were put in place for staff where it was determined that performance was not at the desired standard, adequate supervision measures were not put in place for staff to ensure that residents were at all times safe.

Significant improvements were also required in relation to medication management. Following the administration of medicines, nurses did not always sign the medication administration record. On at least one occasion a number of residents did not receive their prescribed medicines.

Additional improvements required, included:

- preventive maintenance of fire safety equipment
- attendance by staff at training in recognising and responding to abuse
- attendance by staff at fire safety training

The action plan at the end of this report sets out the actions necessary 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.

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

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There were adequate resources available to support the effective delivery of care. There was a clearly defined management structure. The person in charge reported to the provider and was supported in her role by a clinical nurse manager. There was also an operations manager who was responsible for non-clinical issues.

While there was a clearly defined management structure, improvements were required in relation to management systems to ensure that the service provided was safe. For example, an investigation conducted into the unexplained bruising of a resident, that is presumed to have occurred as a result of a fall, was not sufficiently comprehensive. The investigation did not give adequate consideration or explore in more detail the assessments carried out by an allied health professional into the physical ability of a resident immediately after a suspected fall. Based on documentation viewed by inspectors, there was inadequate supervision of the resident during the night but this was not a finding of the investigation. Additionally, recorded supervision checks that are carried out to ensure residents are safe did not accurately reflect actual supervision checks carried out on the night in question. Again, this was not adequately addressed in the investigation.

There was also a lack of understanding of the regulatory requirements by the provider and person in charge in relation to the management of the centre. For example, as will be outlined in Outcome 10 of this report, notifications were not always submitted as required and at least one notification contained inaccurate information.

Inspectors were not satisfied that staff were always supervised relevant to their role and abilities. While performance improvement plans were put in place for staff where it was determined that performance was not at the desired standard, adequate supervision measures were not put in place to ensure that residents were at all time safe.

As discussed under Outcome 8, fire safety equipment was not serviced annually as required and management only became aware of the outdated service when it was pointed out to them by inspectors.

There were regular clinical governance meetings that were attended by the provider, person in charge, operations manager and clinical nurse manager. There was an annual review of the quality and safety of care. There were a number of audits carried out throughout the year, such as medication management audits, accident and incident audit, care plan audits, and a weekly clinical audit. There was an associated action plan identifying who was responsible for addressing the issues identified for improvement through the audit process.

Judgment:

Non Compliant - Major

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:

There was a person in charge who was a registered nurse, worked full time and had adequate experience in the area of nursing of the older person. There was evidence that the person in charge was involved in the day to day running of the organisation and residents could identify the person in charge.

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.

<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: Improvements were required in relation to records management. For example:</p> <ul style="list-style-type: none"> • when inspectors reviewed the care plan of a deceased resident it was discovered that the record was incomplete. Sections of the record were stored separately and were not readily accessible • medication administration records were not always accurately completed • certificates of maintenance of fire alarm and emergency lighting were not available in the centre
<p>Judgment: Non Compliant - Moderate</p>

<p><i>Outcome 06: Absence of the Person in charge</i> <i>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.</i></p>
<p>Theme: Governance, Leadership and Management</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The person in charge was proposing to be absent from the centre for a period in excess of 28 days. This was a planned absence, however, HIQA were not notified of this one month prior to the planned absence as required by the regulations or of the arrangements in place for managing the centre in the absence of the person in charge.</p>
<p>Judgment: Non Compliant - Moderate</p>

<p><i>Outcome 07: Safeguarding and Safety</i> <i>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.</i></p>

Theme:

Safe care and support

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

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

Findings:

There was a policy on safeguarding residents from abuse. The only form of restraint in use was bedrails and where these were in place, a risk assessment had been done. Where it was identified that bedrails were unsuitable, for example, for residents that may attempt to climb over bedrails, bedrails were removed and alternative options explored. A number of residents also had movement alarms in place as a falls prevention measure. A restraint register was maintained and there were records of regular safety checks while bedrails were in place. However, inspectors were not satisfied that records of safety checks accurately reflected actual observation of each resident.

Training records given to inspectors indicated that most, but not all, staff had attended training in recognising and responding to abuse. Staff members spoken with by inspectors were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse. A small number of residents presented with responsive behaviour. Staff were knowledgeable of individual resident's behaviour needs and how to support residents at times of distress. There were care plans in place identifying triggers to particular behaviours and what to do to de-escalate the behaviour.

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 an up-to-date safety statement that was signed and dated. There was an up-to-date risk management policy and associated risk register that addressed the risks specified in the regulations. The provider had identified some of the most relevant and on-going risks and made them available in a separate folder so that they were readily accessible to staff. Inspectors viewed the accident and incident log and there was

evidence of review of each incident with documented learning outcomes to minimise reoccurrence. There was an emergency plan identifying what to do in the event of an emergency, including the safe placement of residents in the event of a prolonged evacuation.

Inspectors reviewed fire safety records. Records indicated that it was in excess of 12 months since fire safety equipment, such as fire extinguishers, were last serviced. When this was pointed out to the provider he immediately arranged for the equipment to be serviced and this was done on the second day of the inspection. Records indicated that the fire alarm and emergency lighting were serviced quarterly. While, signed certificates were not available in the centre detailing the servicing of this equipment there were other records available to demonstrate that it had been completed. The provider undertook to ensure certificates would be available in the centre in the future. Fire safety training was underway on the first day of the inspection. Training records given to inspectors, however, identified that not all staff had attended annual training in fire safety, as outlined in HIQA guidance, Fire Precautions in Designated Centres 2016. Fire drills were conducted regularly and adequate records were maintained of any learning from the drills. A process was underway whereby each staff member was provided with individualised training on the evacuation of residents from the upper floor using a manikin as a training aid. Personal emergency evacuation plans were put in place for all residents, identifying the most appropriate means of evacuating each resident. Staff members spoken with by inspectors were knowledgeable of what to do in the event of a fire, including horizontal evacuation and identifying the location of a fire on the fire alarm panel.

A number of residents smoked. There was a designated smoking shelter with a fire blanket and fire extinguisher located proximal to the shelter. Residents that smoked had a risk assessment completed and care plan in place to identify the level of access to cigarettes and lighters and the supervision required when smoking. This was seen to be reviewed and updated as the condition of the resident changed and when supervision was required.

Judgment:

Substantially Compliant

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):

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

Findings:

There were written policies and procedures in place in relation to medication

management. Medications were stored appropriately and there was a system in place for returning unused and out-of-date medicines to the pharmacy. Medications requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded. Medications requiring special control measures were counted at the end of each shift by two nurses.

It had been identified that the medication administration record (MAR) was not always signed by nursing staff following administration of medicines. Management had taken steps to address this, including on-going audit of MARs and the implementation of a performance improvement plan when management thought this was necessary. Inspectors were not satisfied, however, that the issue had been addressed satisfactorily. For example, on one occasion a number of residents did not get medication that was due at 18:00hrs. There was nothing written in the MAR to indicate why this medication was not given. It was discovered that the medication was accidentally omitted by the nurse. However, another nurse subsequently completed the MAR indicating that the medicine was withheld, which did not accurately reflect what had happened. Stock control checks of PRN (as required) medicines identified that on at least two occasions PRN medicines had been given but not recorded.

Improvements were also required in relation to communicating changes in residents' prescriptions to the pharmacy. For example, a GP had discontinued a medication on the prescription sheet but this was not communicated to the pharmacy. Staff continued to administer the medicine after the date of discontinuation. The error was discovered through an audit conducted by the pharmacist.

Judgment:

Non Compliant - Moderate

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:

Significant improvements were required in relation to submission of notifications to HIQA. For example:

- notifications of serious injury requiring immediate medical and or hospital treatment were not submitted for a resident that had sustained a fracture in a fall or for a resident that had significant soft tissue injury suspected to have occurred following a fall
- the cause of death for one resident was inaccurate and inspectors were not satisfied that it was reported appropriately.

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):

No actions were required from the previous inspection.

Findings:

Routines and practices supported residents to maintain their independence. Residents were supported to go to bed and get up in the morning at a time of their choosing. Residents that chose to have breakfast in their rooms were facilitated to do so and some residents were seen to have their breakfast in the dining room at various times throughout the morning. Some residents were seen to make cups of tea/coffee for themselves whenever they wished. Residents were encouraged to maintain their independence in relation to mobility and a number of residents were seen to move freely around the centre with the assistance of mobility aids. There was a good programme of activities and residents were seen to participate in activities enthusiastically.

Inspectors reviewed a sample of residents' assessments and care plans. Pre-admission assessments were completed on all residents. Residents were comprehensively assessed on admission using recognised assessment tools for issues such as the risk of falling, the risk of malnutrition, the risk of developing pressure sores and mobility status.

Care plans were developed for issues identified on assessment. Many of the care plans were person centred and were reviewed regularly. However, not all care plans were person centred, not all care plans had up-to-date reviews, and the reviews did not always result in care plans being updated with relevant information. For example, the care plan for one resident relating to mobilisation did not reflect the fact that the resident had a number of falls since the last care plan review. The care plan for another resident relating to safe environment didn't refer to the deteriorating eyesight of the resident or that a motion sensor was in place to alert staff if the resident got out of bed.

Residents had access to the services of a general practitioner (GP) and records indicated residents were reviewed regularly. Out-of-hours GP services were also available. Residents had access to allied health/specialist services such as physiotherapy, speech and language therapy (SALT), chiropody, dietetics, and palliative care services.

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):

No actions were required from the previous inspection.

Findings:

A review of the staff roster indicated that the person in charge worked from Monday to Friday and was supported by a clinical nurse manager. The clinical nurse manager was supernumerary for a number of short shifts each week. There were two registered nurses on duty each day from 07:30hrs to 19:30hrs. There were six healthcare assistants on duty each morning until 13:30hrs, five until 18:00hrs, four until 19:30hrs, and three until 22:30hrs. There was also a dining room assistant on duty from 08:30hrs until 11:30hrs to assist residents with breakfast. There was one nurse and two healthcare assistants on duty each night. Additional staff included housekeeping, a chef, a kitchen porter, an activities coordinator, a laundry assistant, an operations manager and two administration staff. Based on a review of records, inspectors were not satisfied that there were sufficient numbers of staff on duty at all times, particularly when some residents presented with responsive behaviour resulting in delays in meeting the needs of other residents.

A review of a sample of staff files indicated that most of the requirements of the regulations were met. While there were an adequate number of references available for each staff member, a number of these commenced with "To whom it concerns". Even though inspectors were informed that these references were verified, this was not documented.

There were records available of the appraisal of staff. Where the appraisal indicated that performance was not at the desired standard, performance improvement plans were put in place to support and supervise staff. However, inspectors were not satisfied that the supervision arrangements were always adequate. For example, even though there continued to be concerns in relation to the performance of the staff member, they were at times on duty without supervision and responsible for supervising other members of

staff.

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:

John Greaney
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:	Powdermill Nursing Home & Care Centre
Centre ID:	OSV-0004456
Date of inspection:	22 & 23/05/2017
Date of response:	14/07/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Governance and management structures were inadequate as evidenced by:

- an investigation conducted into the unexplained bruising of a resident, that is presumed to have occurred as a result of a fall, was not sufficiently comprehensive
- notifications were not always submitted as required and at least one notification contained inaccurate information.
- adequate supervision measures were not put in place to ensure that residents were at

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

all time safe in instances where there were concerns in relation to staff performance

- fire safety equipment was not serviced annually as required and management only became aware of the outdated service when it was pointed out to them by inspectors.

1. Action Required:

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

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

A provider led investigation was completed after the inspection and further learning outcomes from the investigation have already been implemented.

A folder containing up to date HIQA guidance has been compiled in the nurses' station as an easy guide to notifications. All notifiable events will be submitted to the chief inspector in writing within the required timeframes.

Supervision measures have been reviewed and changes were initiated on Monday 29th May.

Fire safety equipment was serviced up to the end of April 2017. The annual service had lapsed by 3 weeks. The equipment was fully serviced on the second day of the inspection. All fire safety equipment was in working order at all times. Our maintenance tracker will ensure a check is complete one month prior to the expiration in 2018 and thereafter.

Proposed Timescale: 19/06/2017

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:

Improvements were required in relation to records management. For example:

- when inspectors reviewed the care plan of a deceased resident it was discovered that the record was incomplete. Sections of the record were stored separately and was not readily accessible
- medication administration records were not always accurately completed
- certificates of maintenance of fire alarm and emergency lighting were not available in the centre.

2. 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:

Sections of the record in question were stored in a file being used by the Director of Care to complete an investigation which had recently been finalised. The complete record was made available to the inspector on the day of inspection.

Weekly medication audits will be carried out for 3 months up to 31st August 2017 and every fortnight thereafter. The Director of Care will review these audits regularly. All nursing staff have committed to learn from these omissions and not repeat them.

It was acknowledged by the inspectors that work on the emergency lighting had been completed but the certification was not available on the day. This has been discussed with our electrician and certificates will be issued every quarter when the work is complete. Up to date certificates are now available in the nurse's station. Evidence of servicing of the fire alarm system is recorded in the fire register book and that information was available to inspectors on the day of inspection. However certificates were not on file but are now available in the red box by the fire panel in the nurses' station.

Proposed Timescale: 19/06/2017

Outcome 06: Absence of the Person in charge

Theme:

Governance, Leadership and Management

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

The person in charge was proposing to be absent from the centre for a period in excess of 28 days. This was a planned absence, however, HIQA were not notified of this one month prior to the planned absence as required by the regulations.

3. Action Required:

Under Regulation 32(1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

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

The person in charge was retiring and a new person in charge was being recruited. Early indications were that the new PIC would have to serve 4 weeks' notice which would have meant the PIC would only have been absent for 2 weeks. However the new PIC was asked for a further 3 weeks' notice in his current position which he agreed to serve. We did not anticipate that we would be in breach of notification requirements. A notification has now been submitted. The provider will ensure that this will not reoccur

Proposed Timescale: 23/05/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

A restraint register was maintained and there were records of regular safety checks while bedrails were in place. However, inspectors were not satisfied that records of safety checks accurately reflected actual observation of each resident.

4. Action Required:

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

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

Regular safety checks for residents using restraint have been reviewed by the Director of Care and the Provider. Observation sheets have been revised to accurately reflect actual observations and safety checks being completed by staff

Proposed Timescale: 19/06/2017

Theme:

Safe care and support

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

Training records given to inspectors indicated that most, but not all, staff had attended training in recognising and responding to abuse.

5. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Our induction process has been reviewed and will now incorporate increased training for new staff members. We have an approved HSE standard trainer among the staff. One training session was held on the 6th of April and another has taken place on the 29th of June. All existing staff have on-going training in recognising and responding to abuse.

Proposed Timescale: 29/06/2017

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:

Records indicated that it was in excess of 12 months since fire safety equipment, such as fire extinguishers, were last serviced.

6. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

The fire safety equipment was fully serviced on the second day of the inspection. All fire safety equipment was in working order at all times. Our revised maintenance tracker will ensure a check is complete one month prior to the expiration in 2018 and thereafter. Daily checks are carried out on means of escape and are recorded in the fire register. In addition weekly checks of fire doors, fire extinguishers and break glass units are carried out and any deficiencies are corrected.

Proposed Timescale: 23/05/2017

Theme:

Safe care and support

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

Training records given to inspectors indicated that not all staff had attended annual training in fire safety, as outlined in HIQA guidance, Fire Precautions in Designated Centres 2016,.

7. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

The 4 staff members indicated on our own training tracker have now completed fire training. Two training sessions have been completed this year and another two are scheduled. We aim to train all staff annually as indicated in the guidance on fire prevention. This exceeds the standard in the regulations.

Proposed Timescale: 01/06/2017

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:

Significant improvements were required in relation to medication management. For example:

- the medication administration record (MAR) was not always signed by nursing staff following administration of medicines
- on one occasion a number of residents did not get medication that was due at 18:00hrs
- a nurse completed the MAR indicating that a medicine was withheld, which did not accurately reflect what had happened
- stock control checks of PRN (as required) medicines identified that on at least two occasions PRN medicines had been given but not recorded
- improvements were also required in relation to communicating changes in residents' prescriptions to the pharmacy to ensure medicines were administered as prescribed.

8. 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:

Medication Management Process has been reviewed so as to insure compliance with legislation and best practice.

Each registered nurse on duty has agreed to self-audit by checking during and at the end of the shift that all medication is administered as prescribed, checked and accounted for and signed as required. In addition the P.I.C. will check a sample of the residents medication records regularly when on duty to ensure that there are no recurring medication errors.

All changes to the Central Prescription Record made by the G.P. on his visit will be communicated to the Pharmacy immediately after the G.P. has concluded his round. The registered nurse completing the rounds with the G.P is responsible for notifying the pharmacy of any changes in prescriptions.

The P.I.C./CNM will conduct weekly audits up to the 31st August 2017 to ensure that all aspects of medication management, including changes made by the G.P. are checked for accuracy and have been communicated to the Pharmacy in a timely manner. They will also ensure that all changes are recorded in the Central Prescription Record and the M.A.R. sheet is updated.

A monthly medication meeting between the Provider, the Person in Charge and the CNM will take place to review medication management. The PIC will report on progress to ensure that improvements are sustained.

Proposed Timescale: 31/07/2017

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:

Significant improvements were required in relation to submission of notifications to HIQA. For example:

- notifications of serious injury requiring immediate medical and or hospital treatment were not submitted for a resident that had sustained a fracture in a fall or for a resident that had significant soft tissue injury suspected to have occurred following a fall

9. 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 person mentioned above suffered 2 falls within 2 days and an NFO3 was submitted after the second fall. The person in charge acknowledges an NF03 should have been submitted after the first fall.

The Registered Provider and the new Director of Nursing have reviewed the HIQA guidelines on submitting notifications. A folder containing up to date HIQA guidance has been compiled in the nurses' station as an easy guide to notifications. All notifiable events will be submitted to the chief inspector in writing within the required timeframes.

Proposed Timescale: 03/07/2017

Theme:

Safe care and support

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

Significant improvements were required in relation to submission of notifications to HIQA. For example:

- the cause of death for one resident was inaccurate and inspectors were not satisfied that it was reported appropriately.

10. Action Required:

Under Regulation 31(2) you are required to: Inform the Chief Inspector in writing of the cause of an unexpected death when that cause has been established.

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

The resident being referred to here had an underlining COPD diagnosis. When

submitting the quarterly notification COPD was listed as cause of death. This error was not intentional. The new Director of care will ensure quarterly notification will be submitted accurately in the future based on certified cause of death.

Proposed Timescale: 19/06/2017

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:

Not all care plans were person centred, not all care plans had up-to-date reviews, and the reviews did not always result in care plans being updated with relevant information. For example, the care plan for one resident relating to mobilisation did not reflect the fact that the resident had a number of falls since the last care plan review. The care plan for another resident relating to safe environment didn't refer to the deteriorating eyesight of the resident or that a motion sensor was in place to alert staff if the resident got out of bed.

11. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

We have started to review and update all our care plans and assessments will be completed in line with Regulations. In addition all the Actions of Daily Living (ADL's) will be reprinted and colour coded to assist the nurse carrying out the four monthly review. The resident will be consulted for their input into their care plan (or family members where the resident is unable to advocate for themselves). A guidance folder on Care Plan reviews has been put together by the new Director of care as a guide for each staff nurse on completing a comprehensive care plan review. In addition the director of care will complete a short training with each staff nurse on using the guidance folder on care planning thus ensuring that each nurse is competent to complete the review.

Proposed Timescale: 31/08/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Inspectors were not satisfied that the supervision arrangements for staff were always adequate. For example, even though there were concerns in relation to the performance of a staff member, they were at times on duty without supervision and responsible for supervising other members of staff.

12. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Supervision measures have been initiated and changes were implemented to rostering on Monday 29th May. This supervision has continued to date and will be reviewed by the new Director of care as to the necessity of on-going supervision.

Proposed Timescale: 31/07/2017