

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Maple Court Nursing Home
<b>Centre ID:</b>	OSV-0005532
<b>Centre address:</b>	Dublin Road, Castlepollard, Westmeath.
<b>Telephone number:</b>	044 966 2918
<b>Email address:</b>	Maplecourtnh@eircom.net
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Fáinleog Teoranta
<b>Provider Nominee:</b>	Pat Shanahan
<b>Lead inspector:</b>	Una Fitzgerald
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	19
<b>Number of vacancies on the date of inspection:</b>	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.

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 1 day(s).

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

From: 25 July 2017 09:00 To: 25 July 2017 17:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This was the centre's first inspection under the new registered provider entity Fainleog Teoranta. The governance and management structure within the centre had undergone significant change in the preceding six months. HIQA have also been notified that there is a further change to the provider nominee and this change had been communicated to residents and staff at a recent residents' meeting held in July 2017. There will also be a further change to the person in charge arrangements. The inspector met with the current person in charge, the proposed incoming person in charge and the provider nominee.

On arrival to the centre, the inspector met with the person in charge who was informed of the purpose of the inspection. During the inspection, the inspector spoke with residents and staff. Residents who spoke with inspectors expressed satisfaction with the services provided and were complimentary of the staff and the care they received.

Overall, the inspector found that the care was delivered to a good standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The management and staff of the centre were striving to improve outcomes for residents. A person-centered approach to care was noted. Residents had good

access to health and social care services and expressed satisfaction with the assistance and support they received in the centre. Relatives spoken to were complimentary of the care.

The premises was designed and laid out to meet the needs of the residents. The incoming provider nominee assured the inspector that the centre was well resourced in order to ensure the delivery of care as described in the statement of purpose. The provider nominee has also committed to ensuring that further development work is carried out within the centre to improve on the environment for residents as referenced in the resident and relative meeting from July 2017.

The person in charge confirmed that all staff have completed Garda vetting.

Of the eight outcomes inspected four were found to be compliant/substantially compliant. Moderate non compliance was found fewer than four outcomes that highlight the changes required to ensure that the centre provides a service that is safe, appropriate, consistent and effectively monitored in line with regulatory requirements. The findings are discussed throughout the report and areas for improvement are outlined 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 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):**

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

**Findings:**

The statement of purpose is currently under review and the provider nominee gave reassurance that HIQA will receive the new document once finalised to reflect the recent changes to governance and management personnel. The new management structure has identified clear lines of authority and accountability, and specified roles and responsibilities for all aspects of the service.

Management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored required further development. The inspector observed that known risk was not addressed in a timely manner. This is discussed under fire and actioned under Outcome 8. On the day of inspection the inspector saw evidence that audits are currently carried out in relation to falls management, pressure sores, mattresses and care plans. The incoming management team clearly outlined to the inspector the broader proposed audit schedule that will be implemented. For example, it was identified that audits are required in key areas such as infection control practices within the centre.

Residents' privacy was not fully respected by the storage of confidential information. Archived files were found stored in an unlocked cupboard within the visitors room. The files were stored in a lockable press that was left open.

The person in charge had commenced a review of all policies required under Schedule 5 of the regulations. There was evidence that progress had been made and this will be addressed with the new management system being implemented. The Director of services reassured the inspector that the policies will be centre specific to Maple Court Nursing Home. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, a review of the detail was required to ensure that all notifiable incidents are accurate. For example, the last

notification that was received into HIQA contained information that was not reflective of the detail contained within the resident file.

There were policies and procedures for the management of complaints. The complaints process was displayed in a prominent place in the reception area. The inspectors reviewed the complaints log. Records indicated that complaints were minimal, a total of one to date in 2017. Residents were informed on admission of the complaints procedure. The inspector reviewed the documentation of the complaint received. A record of the outcome was documented and there was also detail if the complainant was satisfied with the outcome. The centre had an appeals officer and also directed the complainant to the office of the Ombudsman if unhappy with the outcome. Residents spoken with on the day told inspectors that they would not hesitate to make a complaint if they had one. Relatives said that they were satisfied with the care and were aware of who they could complain to if they needed to.

**Judgment:**

Non Compliant - Moderate

***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):**

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

**Findings:**

The person in charge commenced working within the centre in March 2017. The whole time equivalent hours were divided out between Maple court nursing home and another designated centre within the same group.

Reorganisation of the governance and management system in place is undergoing further significant change. There is now a newly appointed provider nominee and person in charge for this centre. The inspector met with the incoming person in charge during the inspection. The incoming person in charge notification has yet to be received by HIQA. This role is going to be based across two centres and supported by the existing PPIM in Maple court.

Through a process of one to one conversation the incoming person in charge demonstrated sufficient knowledge of the role and statutory responsibility.

**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):**

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

**Findings:**

Measures were in place to protect residents from being harmed or abused. There was a current policy which provided guidance for staff on the various types of abuse, assessment, reporting and management of allegations or incidents of elder abuse.

Staff confirmed and training records indicated that all staff had attended training on the prevention, detection and response to abuse. Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were put in place to ensure the safety and welfare of residents.

Systems and arrangements were in place for safeguarding resident's finances and property. The centre currently acts as a pension agent for one residents. Documentation was reviewed and the person in charge confirmed that all monies are held in a separate resident account.

An aim to promote a restraint free environment in line with the national policy was described. A restraint policy last updated in March 2017 was available. From review of the chemical restraint register there was no reported use of chemical restraint. However, the inspector found evidence that there had been two incidents of chemical restraint in May 2017. The documentation was inconsistent and had significant gaps.

Monthly reviews of bedrail use was maintained and recorded. Staff and records confirmed that one resident was using bedrails that restricted movement. The restraint policy clearly defined restraint and outlined the types of restraint, assessment, checks and review practices. Alternatives such as low low beds and bed bumpers were available. The inspector reviewed the resident file. There was a care plan in place. However, a consent form was not signed. There was no record kept of the duration of restraint and safety checks or releases recorded. This was discussed with the nurse management team. The nurse manager addressed these gaps during the inspection. A risk assessment was carried out, the general practitioner was consulted with on the decision, the care plan was updated and the resident signed a consent form.

The centre has a policy on and procedures in place to support staff with working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice and implemented by staff. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours that challenge. The person in charge informed the inspector that among the current residents there was no resident that had responsive behaviours.

**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):**

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

**Findings:**

The centre had policies and procedures relating to health and safety. The health and safety statement provided to the inspector for review was dated January 2017. The centre had a risk management policy that includes items set out in Regulation 26(1). The centre had a current risk register that identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents. The inspector was informed that the register was updated last week but there was no documentary evidence to confirm this.

Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. The standard of cleanliness and the systems to ensure that the infection control practices are audited throughout the centre required review. While processes were in place they were not clear to the staff. The cleaning schedules reviewed on the doors of communal bathrooms had gaps in the recordings. On inspection of the smoking room the inspector noticed a heavily soiled apron on the floor of the smoking room at 09.20am. This was brought to the attention of staff - this apron was not removed until post 15.10. The inspector also observed within the communal assisted bathroom that the floor was in poor state of repair. The toilet seat was stained. There were two used razors on the windowsill. There were four shower chairs that had multiple areas of rust that compromise cleaning ability.

Suitable arrangements were in place in relation to promoting fire safety. The fire alarm system was serviced bi annually. Fire safety equipment was serviced on an annual basis. Fire safety and response equipment was provided. Fire exits were identifiable by signage and exits were unobstructed to enable means of escape. Fire evacuation procedures



were prominently displayed throughout the building. Training records indicated that all staff had received training. The inspector reviewed the documentation on the last fire drill simulation which contained the detail required. Staff on duty had knowledge of the procedure to follow in the event of a fire.

On review of the documentation on fire equipment services dated the 17/07/2017 the engineer stated that "the fire alarm could not be tested as the fire panel cannot be put into test or disabled and needs to be upgraded urgently" To date no action had been taken on this advice. The inspector spoke with the incoming management team who actioned the purchase and implementation of a new fire panel. The replacement will be installed on the 31/07/2017. The engineer confirmed that in the event of a fire the system would alarm.

**Judgment:**

Non Compliant - Moderate

***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):**

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

**Findings:**

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Medicine management policies have been updated since the new appointment of the person in charge. However, further review is required. For example, the policy on double checking states that two nurses should sign for all medicines. However, the centre only has one nurse on duty and is non compliant with their own policy.

An audit of the medicines management system was carried out monthly. The inspector requested to review the medicine incident log and to date in 2017 there has been no incidents. The inspector reviewed the template for reporting and was reassured that the system would ensure follow up and learning would occur.

The processes in place for the handling and checking of medicines received including controlled drugs were examined. Practices found and procedures described were in accordance with current professional guidelines and legislation.

Prescription and administration records were maintained in accordance with the centre's policy and professional standards.

A system was in place for prescription review by the resident's general practitioner and

pharmacist every three months or more frequently if indicated.

**Judgment:**

Substantially 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):**

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

**Findings:**

Residents' health and care needs were met through timely access to medical treatment. Residents had good access to a general practitioner and allied healthcare professionals. The inspector focused and tracked the journey prior to and from admission of a number of resident files. The review looked at specific aspects of care such as, wound care, mobility, access to health care and supports.

The inspector saw good evidence that advice received from the multidisciplinary team was followed up in a timely manner. The detail of reviews carried out was evident within the records. The centre had a system whereby each resident had a named key nurse. This system ensured that each care plan was person centered and guided care.

On admission all residents had a comprehensive nursing assessment. The inspector observed that initial care plans were written within the 48 hour timeframe as per the regulations. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, level of mobility, falls risk assessment and skin integrity. Assessment outcomes were linked to care plans that were seen to be reviewed in consultation with the resident and family at intervals of three months and more frequently when clinically indicated. There was good evidence contained within the communication sheets that the resident and their family were kept updated and involved in care discussions. This was also confirmed during conversations had by the inspector with residents and family.

Clinical observations such as blood pressure, pulse and weight were assessed on admission, and as required thereafter. A care plan was developed following admission. In the sample reviewed, information following the assessment, involvement and recommendations of allied healthcare professionals was reflected. Care was seen to be delivered to each resident in accordance with their identified needs.

Staff provided end of life care to residents with the support of their general practitioner and have access to specialist community palliative care services if required. Each file reviewed had an end of life care plan. This care plan is kept under regular review and was updated in consultation with the resident and where appropriate a family member. There was no resident receiving end of life care on the day of inspection. Staff outlined how religious and cultural practices were facilitated within the centre.

Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked. There was a system in place to ensure that special dietary requirements are communicated between the clinical team and kitchen staff. The processes in place ensure that residents do not experience poor nutrition and hydration. Any food allergies were clearly recorded along with resident's likes and dislikes.

Residents were assessed to identify their risk of developing pressure related skin injuries. Residents at risk had specific equipment in place to mitigate level of risk, such as repositioning regimes and pressure relieving mattresses and cushions. There was no resident with a pressure ulcer on the day of inspection. The inspector reviewed the file of one resident with a wound. A detailed care plan was available. The inspector reviewed the wound management procedures in place. Tissue viability specialist services were available to support staff with management of any residents' wounds that were deteriorating or slow to heal.

**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):**

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

**Findings:**

The inspector was informed that residents are consulted about how the centre is planned and run. Feedback is sought through resident surveys. The last survey was in March 2017 and overall satisfaction was expressed by residents. Residents have access to independent advocacy services. There were three information boards strategically placed on corridors. On the day of inspection the notice boards were blank of any

information. There was a notice board in the dining room that contained nutritional information for residents.

On the day of inspection the person who coordinated activities was not available and the management team had organized a replacement to fulfil this role. The inspector reviewed the daily documentation records that is kept to ensure that each resident has opportunities to participate in activities that are meaningful and purposeful to their interests and capacities. The documentation did not provide the required assurances. The inspector also reviewed the care plans for activities on three residents and there was significant gaps within the documentation.

The centre has an activities schedule in place. There is a monthly newsletter for residents There is access to a private telephone. The oratory and visitors room has dual purpose and was seen to be used by residents throughout the day.

The new provider nominee had held a resident and family meeting on the 18th July 2017 informing residents of the new changes.

**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):**

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

**Findings:**

The actual and planned rosters for staff was reviewed. The inspector found that staffing levels and skill mix were sufficient to meet the needs of residents. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities. Residents spoken to confirmed that they felt their care needs were met by staff. Recruitment and induction procedures were in place. Staff spoken with felt supported by the management team. A meeting was held with staff on the day of inspection communicating the new governance structure.

Evidence of current professional registration for all registered nurses was seen by the

inspector. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. Training included in house mandatory training on safeguarding and safety, patient moving and handling, fire safety and cardio pulmonary resuscitation. All staff nurses had additional requirements such as medication management and dementia training. The training matrix evidenced that all mandatory training was up to date.

All documents as required by Schedule 2 of the regulations for staff were maintained. The person in charge confirmed that all staff have Garda Vetting. There are no volunteers working within the centre.

**Judgment:**

Compliant

## 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:***

Una Fitzgerald  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Maple Court Nursing Home
<b>Centre ID:</b>	OSV-0005532
<b>Date of inspection:</b>	25/07/2017
<b>Date of response:</b>	03/08/2017

### 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:

The person in charge had commenced a review of all policies required under Schedule 5 of the regulations. There was evidence that progress had been made and this will be addressed with the new management system being implemented. The Director of services reassured the inspector that the policies will be centre specific to Maple Court Nursing Home.

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

**1. Action Required:**

Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015.

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

All policies required under Schedule 5 of the regulations will be available in the centre. This process has commenced and the policies will all be centre-specific.

**Proposed Timescale:** 31/08/2017

**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 aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, a review of the detail was required to ensure that all notifiable incidents are accurate. For example, the last notification that was received into HIQA contained information that was not reflective of the detail contained within the resident file.

**2. 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:**

All incidents will be reported and recorded accurately and any notifications required by the Authority will be documented and notified accurately and within the required timeframes.

**Proposed Timescale:** 31/07/2017

**Theme:**

Governance, Leadership and Management

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

The statement of purpose is currently under review and the provider nominee gave reassurance that HIQA will receive the new document once finalised to reflect the new changes.

**3. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and

details responsibilities for all areas of service provision.

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

The statement of purpose has now been reviewed and the updated version, which reflects the new changes, will be sent to the Authority. This clearly defines the management structure and identifies lines of authority and accountability, specific roles and details responsibilities for all areas of service provision, in accordance with Regulation 23(b).

**Proposed Timescale:** 03/08/2017

**Theme:**

Governance, Leadership and Management

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

Management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored required further development. The incoming management team clearly outlined to the inspector the proposed audit schedule that will be implemented.

**4. Action Required:**

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

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

The Registered Provider will introduce effective systems to ensure that the service provided is safe, appropriate and consistent. A comprehensive audit schedule will be implemented to enable regular monitoring of quality, safety, capacity and capability in the centre. The audit tools used are based on regulatory compliance. Action plans will be developed based on any identified areas of non-compliance. The Person in Charge will be supported in the introduction of the quality monitoring systems by the Director of Care Services.

**Proposed Timescale:** 30/09/2017

**Theme:**

Governance, Leadership and Management

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

Residents' privacy was not fully respected by the storage of confidential information. Archived files were found stored in an unlocked cupboard within the visitors room. The files were stored in a press that was left open.

**5. 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:**

All resident files will be stored securely and safely in locked cupboards that may only be accessed by the Person in Charge and appropriate designated individuals in the centre.

**Proposed Timescale:** 31/08/2017

**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:**

Monthly reviews of bedrail use was maintained and recorded. Staff and records confirmed that one resident was using bedrails that restricted movement. A consent form was not signed. There was no system in place to record the duration of restraint and safety checks.

**6. 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:**

Where restraint is required, it is used in accordance with national policy on the use of restraint in designated centres. Restraint will only be used as a measure of last resort, following an assessment of the resident and consideration of appropriate alternatives; the resident's consent to the use of restraint will be sought where possible and there will be regular reviews of the need for restraint, Safety checks will be recorded according to the frequency indicated. Records will be maintained of the assessment, consent, review and safety checks for all restraints used in the centre. The Authority will be notified on a quarterly basis about the use of restraint in the centre. The Person in Charge will continue to promote a restraint-free environment as much as possible.

**Proposed Timescale:** 31/08/2017

**Theme:**

Safe care and support

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

A restraint policy last updated in March 2017 was available. From review of the chemical restraint register there was no reported use of chemical restraint. However,

the inspector found evidence that there had been two incidents of chemical restraint in May 2017. The documentation was inconsistent and had significant gaps.

**7. 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:**

Where restraint is used, it will always be used in accordance with national policy on the use of restraint in designated centres. Where chemical restraint is indicated, there will be a clear understanding by staff about the conditions for use. Antecedent, Behaviour and Consequence (ABC) charts will be recorded to identify responsive behaviours. A person-centred care plan will be developed to describe the triggers for responsive behaviours and any known de-escalation techniques that should be employed prior to the use of chemical restraint. The use of chemical restraint will be recorded consistently and accurately, and the use of chemical restraint will be reported on a quarterly basis to the Authority as per the NF39 notification requirements.

**Proposed Timescale:** 31/08/2017

**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:**

The centre had a current risk register that identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents. The inspector was informed that the register was updated last week but the documentation and evidence was not available for review.

**8. Action Required:**

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

We will ensure that the Risk Register is up to date and available for inspection by the Authority as required. The Risk Register will include the physical and environmental risks identified in the centre and the control measures in place to minimise any negative impact on residents.

**Proposed Timescale:** 31/08/2017

**Theme:**

Safe care and support

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

The cleaning schedules reviewed on the doors of communal bathrooms had gaps in the recordings. The standard of cleanliness and the systems to ensure that the infection control practices are audited throughout the centre required review.

**9. Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

The procedures and standards for the prevention and control of healthcare associated infections published by the Authority will be implemented by staff. The Person in Charge will monitor the standards of cleaning and hygiene in the centre and an action plan will be developed to address any identified areas of non-compliance and improvements required.

**Proposed Timescale:** 31/08/2017

**Theme:**

Safe care and support

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

The fire alarm system was serviced bi annually. On review of the documentation on fire equipment services dated the 17/07/2017 the engineer stated that "the fire alarm could not be tested as panel can not be put into test or disabled and needs to be upgraded ASAP" Todate no action had been taken on this advice. The engineer confirmed that in the event of a fire the system would alarm.

**10. Action Required:**

Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

The fire alarm display panel was upgraded on 01/08/17. The fire alarm can now be tested on a regular basis.

**Proposed Timescale:** 01/08/2017

**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:**

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Medicine management policies have been updated since the new appointment of the person in charge. However further review is required. For example, the policy on double checking states that two nurses should sign for all medicines. However, the centre only has one nurse on duty.

**11. 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:**

The policy on double checking refers specifically to the stock checking of controlled drugs. This is done at the beginning and end of each shift (twice per day) by the nurse ending her shift and the nurse starting the next shift. If controlled drugs are to be administered, the drug can be checked by a nurse and the register can be signed by a care assistant to verify the number remaining, in accordance with the medicines management policy in the centre. All other medicines are administered by the nurse on duty without the requirement for double checking, in accordance with the medicines administration policy in the centre.

**Proposed Timescale:** 31/07/2017

**Outcome 16: Residents' Rights, Dignity and Consultation**

**Theme:**

Person-centred care and support

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

The inspector reviewed the daily documentation records that is kept to ensure that each resident has opportunities to participate in activities that are meaningful and purposeful to their interests and capacities. The inspector also reviewed the care plans for activities on three residents and there was significant gaps within the documentation.

**12. 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 review of the activities schedule for residents will be undertaken by the Person in Charge, who will ensure that each resident has an opportunity to participate in activities that are meaningful and purposeful to their interests and capacities. There will be a range of varied activities available for residents, based on their preferences and choices

and the schedule will cater for groups as well as individual activities. An Activities Coordinator will be responsible for the activities schedule.

**Proposed Timescale:** 31/08/2017