

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Claremount Nursing Home
Centre ID:	ORG-0000329
Centre address:	Claremount, Claremorris, Mayo.
Telephone number:	094 937 3111
Email address:	amhegarty@yahoo.co.uk
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Claremount Nursing Home Limited
Provider Nominee:	Ann Marie Hegarty
Person in charge:	Fiona Geraghty
Lead inspector:	Lorraine Egan
Support inspector(s):	Jackie Warren;
Type of inspection	Unannounced
Number of residents on the date of inspection:	57
Number of vacancies on the date of inspection:	3

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 judgements about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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: 27 February 2014 09:15 To: 27 February 2014 20:30

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

Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 15: Food and Nutrition
Outcome 18: Suitable Staffing

Summary of findings from this inspection

As part of this monitoring inspection the inspectors met with residents, care assistants, staff nurses, the person in charge and the provider. The inspectors observed practices and reviewed paperwork including policies, care plans, medical records, risk assessments, training records and staff files.

While evidence of good practice was found in many areas of the service, some areas required significant improvements. The inspectors found there were measures in place to ensure residents were safeguarded against abuse and residents spoken with told the inspector they felt safe. Staff spoken with had a good knowledge of residents' individual needs and were observed by inspectors as engaging with residents in a respectful manner. Staff had access to regular training in a wide range of areas and the skill mix of staff present on the day of the inspection was found to be sufficient to meet residents' needs.

Areas which required improvement included medication management, premises, staffing records, policies and the identification and management of risk in the centre. These non compliances are discussed further in the body of the report and are included in the action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 03: Suitable Person in Charge

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

Theme:

Leadership, Governance and Management

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

The centre is managed by a registered general nurse with the required experience in care of the older person. She works full-time as person in charge and the assistant director of nursing fulfils the role of person in charge in her absence. The inspectors were satisfied the person in charge was knowledgeable of the Regulations and of her responsibilities.

On the day of the inspection the inspectors met with the person in charge throughout the day and observed her interactions with residents and staff. She demonstrated competence and a clear commitment to delivering high quality care to residents. She had a good rapport with residents and was responsive to residents needs.

She had maintained her continuous professional development and had taken courses in 'Infection Control', 'Leadership' and 'Challenging Behaviour in Care of the Older Person' in 2013 along with attending the Annual Conference on Gerontology. To date in 2014 she had attended a course in 'Quality and End of Life Care'.

Outcome 04: Records and documentation to be kept at a designated centre

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) 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 2009 (as amended).

Theme:

Leadership, Governance and Management

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

No actions were required from the previous inspection.

Findings:

Although this outcome was not inspected against the inspector found some documentation required review. For example, the policy on behaviours which challenge had not been reviewed and some care plans were not legible or sufficiently detailed to guide practice. This is further discussed under Outcome 11.

Outcome 06: 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.

Theme:

Safe Care and Support

Judgement:

Compliant

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector found that measures were in place to protect residents from being harmed or abused.

There was a comprehensive policy on the prevention, detection and response to abuse which included clear lines of responsibility and the steps to be taken in the event the alleged abuser is a member of staff, a senior member of management or a resident. It also included a whistle blowing policy and the contact details of the HSE Elder Abuse Officer, Age Action Ireland and Third Age National Advocacy Programme.

The inspector reviewed the arrangements for the safekeeping of residents' valuables and found that residents' money and valuables were safely secured. The person in charge managed the finances of a small number of residents. Each resident's money and financial records were maintained securely and balances were accurate. Records were maintained of all transactions and were stored in a secure and transparent manner. There were clear procedures in place in the event staff members were given money on behalf of residents and all entries were signed by two staff members with a receipt issued to the family member. The inspector also viewed records pertaining to the return of valuables to resident's families and found clear and transparent procedures in place.

Records viewed by the inspector indicated that staff had received training on identifying and responding to elder abuse. Staff spoken with were able to explain the different categories of abuse and what their responsibilities were if they suspected abuse. The person in charge and the assistant director of nursing had a clear understanding of the action to take if an allegation of abuse was reported.

Residents spoken with confirmed that they felt safe in the centre and said they could speak with a staff member if they needed to.

Outcome 07: Health and Safety and Risk Management

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

Theme:

Safe Care and Support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

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

Findings:

The inspector found that there were systems in place to promote the health and safety of residents, staff and visitors. However, there were a number of areas identified by the inspector which required improvement.

The inspector viewed the emergency evacuation plan and found it to be adequate. The centre had an arrangement with a local hotel and a local nursing home in the event the centre must be evacuated. The centre is a purpose built structure. It had one hour fire doors at intervals along the corridor and the building was divided into zones with a panel in the main lobby. The zones were clearly identifiable on a floor plan which was located beside the panel along with a list of residents and mobility requirements. When the fire alarm is activated the internal fire doors close automatically and all external doors open.

Staff spoken with differed in relation to the person who takes charge in the event of the fire alarm activating. While the policy stated the senior staff nurse on duty takes charge the inspector found this was not a clearly defined role nor was the inspector satisfied that staff were aware of this.

The inspector viewed training records and was satisfied that most staff had received fire safety training. Fire drills were taking place on a regular basis and staff spoken with had a good knowledge of the steps to be taken in the event of a fire. However, there was no identification of learning from fire drills and the inspector was not satisfied that measures had been taken in response to findings. For example, one fire drill documentation showed that staff 'had panicked' and there was no evidence to show that this had informed decision making in relation to any adjustments to fire drills or fire

safety training as a result of this.

The inspector viewed records pertaining to the servicing of the fire alarm, smoke detection system and fire extinguishers and these had taken place in recent months.

The internal fire doors along the north and south corridor were checked by the inspector and one door was found wedged open with a piece of wood. The person in charge told the inspector that the battery needed to be replaced.

The inspector viewed records pertaining to safety checks which are carried out by staff each night and found evidence that some checks were not carried out on a number of dates. There was no evidence that these had been followed up on nor was there a reason documented.

The inspector viewed the emergency plan and found it was not sufficiently detailed in all areas and was not adequate to guide staff in the event of an emergency. The inspector also found it was in conflict with the information given to the inspector by the person in charge and the provider. For example, the person in charge informed the inspector there is generator which will provide heat and light in the event of a power failure and this was not documented in the emergency plan.

There was a fire exit to the enclosed garden, however the gate was locked and the key was stored in the office. The person in charge informed the inspector that this door would not be used in the event of a fire as there are two other available exits in that part of the building. However, this was not documented and staff spoken with were not aware of this.

One staff member required training in fire safety and the person in charge informed the inspector that this staff member would be trained on 8 March 2014. Four staff members required manual handling training which the person in charge informed the inspector was scheduled for 11 March 2014.

The inspector viewed the Health and Safety Statement and found that the date of review had passed and there was no indication it had been reviewed.

The inspector viewed the risk register and found it did not sufficiently identify the measures which would be taken to control the risks identified. The inspector also found the risk register identified risks which were not relevant in the centre and the person in charge verified this. Risks identified were insufficient in some cases and some relevant risks were not identified in the risk register. There was no indication of the person responsible for reviewing the risk register and while some risks had been reviewed in May 2013 and September 2013 some risks had not been reviewed since September 2012.

The inspector was informed by the person in charge and staff that some residents' bedroom doors are left open at night. Staff spoken with identified the reason for this as preference of the resident in some cases and supervision of residents in others. Neither staff spoken with nor the person in charge identified this as a fire safety issue and this was not identified as a risk in the risk register.

The inspector viewed the risk management policy. While the policy identified the risk of assault and self harm, and there were policies on each of these, there were no control measures identified nor were preventative measures identified.

The inspector viewed the Resident Absent Policy and found it to be inadequate as it was not clear how many staff would be allocated to look for the resident nor did it identify who would be called to assist in the search for a missing resident.

The inspector viewed training records which showed that most staff in the centre had received training in Infection Control between 2011 and 2014. However, the inspector found that neither the infection control policy nor the policy on Methicillin-resistant Staphylococcus aureus (MRSA) give guidance on the handling and laundering of infected bed linen.

Outcome 08: Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Safe Care and Support

Judgement:

Non Compliant - Major

Outstanding requirement(s) from previous inspection:

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

Findings:

While the inspector found some evidence of good medication management there were a number of areas which required significant improvement and the inspector issued an immediate verbal action to the person in charge on the day of the inspection due to a medication management risk.

There was documented evidence that medication was reviewed regularly and that residents had access to a general practitioner (GP) as required.

The inspector viewed the centres medication policy and found that it required improvement to include self medication. The medication policy stated that a policy in relation to self administration of medication would be drawn up if a resident expressed a wish to self medicate. On the day of the inspection a staff nurse on duty informed the inspector that two residents self administer some medications. While assessments were evident in the care plans viewed by the inspector, there was no policy in place to support this.

The inspector viewed a sample of residents' medication prescription sheets and drug

recording sheets and found a number of issues including

1. No date of discontinuation of medication on prescription sheet.
2. Times and days medication was to be administered was not clear.
3. In some cases medication was administered at a different time than the time detailed on the prescription sheet.
4. No maximum dose of PRN (as required) medication on some prescription sheets.
5. Discontinued food supplement which was recorded as administered for three days after discontinuation date.
6. Food supplement which was not recorded as administered for 24 days after prescription date.

The inspector found that there were two PRN (as required) medications prescribed for one resident for the same reason. However, the drug prescription sheet did not detail which medication was to be used nor did it give sufficient detail regarding when the medication was to be used. The inspector reviewed this resident's care plan and found that the information entered in relation to the administration of this medication was not legible and this was confirmed by a staff nurse, the person in charge and the provider, none of whom could tell the inspector the procedure detailed in relation to the administration of this medication. The inspector issued an immediate action to the person in charge to resolve this issue as it posed an immediate risk to the resident's care and wellbeing should this situation arise. The person in charge responded immediately and this was resolved on the day of the inspection.

The inspector viewed the controlled drugs register and the controlled drugs press. The controlled drugs were stored in a double locked press and the keys were held by the staff nurse on duty. The controlled drugs were checked by each staff nurse at the beginning and end of each shift. The inspector viewed the controlled drugs in one part of the centre and while the balances were found to be accurate the inspector found a number of issues including:

1. The medication of a resident deceased in 2012 was stored in the controlled drugs press.
2. Discontinued medication for one resident stored in the controlled drugs press.

The inspector viewed the medication fridge which was locked and the temperature was found by the inspector to be correct. One medication stored in the fridge did not have a label on it and a staff nurse told the inspector it would be used for someone prescribed this cream despite it not being evident to whom the cream belonged.

The inspector viewed the medication audits including records of disposal of medication which had been carried out by the assistant director of nursing and by an external pharmacist. While audits were carried out on a number of areas the inspector was not satisfied of the validity of the audits as the audits did not identify issues which the inspector identified during the inspection. There was also no evidence that any learning from audits was disseminated to staff nurses and a nurse spoken with informed the inspector that while she was aware audits were carried out she had not been informed of the findings of any audit.

The inspector was informed by the person in charge and by a staff nurse on duty that medication audits and medication supervision is provided in house by the assistant

director of nursing. However, the inspector was not satisfied that sufficient supervision and training was occurring due to a number of issues which a staff nurse spoken with was unable to clarify for the inspector on the day of the inspection.

Outcome 10: Reviewing and improving the quality and safety of care

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

Theme:

Effective Care and Support

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

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

Findings:

While the inspector did not inspect against this outcome in full, an action from the previous inspection was reviewed.

The action from the previous action plan pertaining to the compilation of an overall report from audits undertaken in the centre was followed up on by the inspector. The inspector found that there was no report of audits available and some audits were found by the inspector to be in conflict with the inspector's findings on the day of the inspection. This is discussed further under Outcome 8.

Outcome 11: Health and Social Care Needs

Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents 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

Judgement:

Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:

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

implemented.

Findings:

The inspector found that while residents had access to a range of health professionals including general practitioners (GP), opticians, dieticians and physiotherapists some improvements were required in relation to care plans.

The centre has employed a physiotherapist Monday to Friday 9am to 2pm which can be accessed by all residents requiring physiotherapy input.

The inspector viewed referrals and hospital letters in residents' files along with medication reviews carried out by general practitioners (GP) and the inspector was satisfied that residents' healthcare needs were being met.

There was evidence of a recent review of some care plans and the addition of information such as activity and continence care.

Residents' dietary requirements were recorded and furnished to the centre's chef. Residents were weighed on a monthly basis and dietetic input was evident in some care plans.

Residents spoken with were satisfied with the level of health care provided and one resident told the inspector that all residents had their eye sight checked in September 2013.

The care plans of a resident pertaining to falls was reviewed and found to be adequate with good processes in place for supporting residents at risk of falls and recent reviews of falls risk assessments.

The inspector viewed the wound care of a resident and found wound care was well managed by the person in charge who is a tissue viability nurse. However, some improvement was required in relation to the documentation which was not specific in relation to types of dressings and frequency of reviews.

The inspector viewed a number of policies and found that improvements were required in relation to the nutrition policy which was not sufficiently detailed to guide practice and this discussed further under Outcome 15.

The inspector viewed a number of care plans on the day of the inspection. While the inspector found that care plans were comprehensive and informative and included a range of assessments such as nutrition, falls assessments, end of life, spirituality, wound assessment, communication, activities and personal care some improvements were required. The issues concerning care plans were as follows:

1. Handwriting in some care plans was not legible.
2. Some care plans were not sufficiently detailed, for example personal care plans.
3. Where restraints were used there was no evidence of any alternatives tried.
4. Missing persons profiles were not adequate as while there was a photo of the residents face there was no physical description of the resident.
5. Some care plans were signed by the next of kin rather than the resident and there

was no explanation as to the reason for this.

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Care and Support

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

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

Findings:

While the inspector did not inspect against this outcome a number of issues were evident on the day of the inspection and the inspector followed up on an action from the previous inspection relating to the use of CCTV in the centre.

The issues noted and of concern to the inspector were as follows:

1. The seating in the oratory was not adequate for the needs of the residents.
2. The screening around beds was not adequate.
3. Assistive equipment was being stored in the hairdressing room.
4. Radiators were very hot to the touch and the person in charge informed the inspector she was not aware of how the temperature is controlled.
5. While there is a suitable enclosed garden it was not easily accessible by residents and a staff member was unable to open the door when asked to do so by the inspector.

CCTV had been removed from the sitting room and was in the hallways, lobby and grounds only.

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

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

Findings:

While the inspector did not inspect against this outcome there was an action from the previous action plan pertaining to the policy and guidelines for documenting residents' nutritional intake.

The inspector found that while there was a nutritional policy in place it was not sufficient to guide practice. For example, it stated that 'staff understand and recognise the signs and symptoms of dehydration' but did not detail what those signs and symptoms are. A staff member spoken with had a good knowledge of the signs and symptoms of dehydration and stated she had attended a team meeting where this was discussed and had a good knowledge of this prior to coming to work in the centre.

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.

Theme:

Workforce

Judgement:

Non Compliant - Minor

Outstanding requirement(s) from previous inspection:

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

Findings:

While inspectors were satisfied there was an appropriate skill mix of staff on duty in the centre, some staff files viewed by the inspector did not comply with the Regulations.

The inspector reviewed the staff rota and found it accurately reflected the staffing levels on the day of the inspection. The inspector found the lines of accountability and the duties of nurses clear and the number of care assistants employed throughout the day was found to be adequate. Other staff employed in the centre included catering staff, cleaning and laundry staff, administration staff, a physiotherapist and two activity coordinators.

The role of the person in charge was supernumerary and the person in charge worked Monday to Friday 9am to 5pm. In the absence of the person in charge the role was fulfilled by the assistant director of nursing. The assistant director of nursing was

interviewed by the inspectors and the inspectors were satisfied that the assistant director of nursing is competent. She was clear in relation to her role and responsibilities and demonstrated to the inspectors that she was aware of the Regulations and her requirements when fulfilling the person in charge role. She had a good understanding of abuse, was clear in relation to the steps to be taken if an allegation of abuse was made and demonstrated her commitment to the welfare of residents at all times. She had maintained her continuous professional development by attending a number of training courses. She supervised staff on a regular basis and liaised with health professionals and families to ensure the care and welfare of residents. She ensured the centre is fully staffed at all times by arranging cover when staff are absent due to sick leave.

The inspector viewed training records and was satisfied that most staff had received mandatory training in fire safety and manual handling. This is discussed further under Outcome 8.

A number of training courses attended by staff included training in restraint, basic nutrition training, continence management, infection control, dementia care and end of life. Three staff members were trained in Sonas and the person in charge informed the inspector that these staff members facilitate four Sonas sessions each week.

A sample of staff files viewed by the inspector did not comply with the Regulations. In one staff file there was no Garda Síochána vetting while another staff members form was not signed. In some staff files a full employment history was not evident and not all files viewed by the inspector had the required three references.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

Lorraine Egan
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:	Claremount Nursing Home
Centre ID:	ORG-0000329
Date of inspection:	27/02/2014
Date of response:	06/05/2014

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 04: Records and documentation to be kept at a designated centre

Theme: Leadership, Governance and Management

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

Some care plans were not legible which compromised the resident's welfare and well-being.

Action Required:

Under Regulation 22 (1) (i) you are required to: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a manner so to ensure completeness, accuracy and ease of retrieval.

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

The illegible Care Plan has been rewritten.

Proposed Timescale: 04/03/2014

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

Theme: Leadership, Governance and Management

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

The policy on behaviours which challenge required review.

Action Required:

Under Regulation 22 (1) (ii) and (iii) you are required to: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

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

This policy will be reviewed by the Person in Charge.

Proposed Timescale: 01/07/2014

Outcome 07: 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 risk register did not contain sufficient detail regarding the precautions in place to control the risks identified.

Risks identified by the inspector on the day of the inspection were not identified as risks in the risk register.

Risks identified were not updated or reviewed.

There was no guidance on the handling and laundering of infected linen.

The incomplete recording of night safety checks by staff was not identified as a risk.

Action Required:

Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

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

The Office Administrator is booked to attend a Health & Safety and Risk Management course in April 2014. She will be responsible for the updating and ongoing review of the Health & Safety Statement and the Risk Register.

The Infection Control Policy will be updated to include the handling and laundering of infected linen.

The night safety check-list is checked every morning to ensure that it is completed from the night before.

Proposed Timescale: 30/07/2014

Theme: Safe Care and Support

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

There are no precautions in place to control the risks of assault and self-harm.

The resident absent without leave policy was not sufficiently comprehensive.

Action Required:

Under Regulation 31 (2) (c) you are required to: Ensure that the risk management policy covers the precautions in place to control the following specified risks: the unexplained absence of a resident; assault; accidental injury to residents or staff; aggression and violence; and self-harm.

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

The Assault and Self Harm Policies will be updated to include precautions and control measures.

The Resident Absent without Permission will be reviewed and updated to sufficiently guide staff.

Proposed Timescale: 06/08/2014

Theme: Safe Care and Support

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

Four staff members did not have up to date training in manual handling.

Action Required:

Under Regulation 31 (4) (f) you are required to: Provide training for staff in the moving and handling of residents.

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

Manual Handling Training was completed on the 11th March 2014.

Proposed Timescale: 11/03/2014

Theme: Safe Care and Support

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

The emergency plan was not sufficiently detailed and was in conflict with information provided by the person in charge and the provider.

Action Required:

Under Regulation 31 (3) you are required to: Put in place an emergency plan for responding to emergencies.

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

The Emergency Plan will be reviewed and updated.

Proposed Timescale: 04/06/2014

Theme: Safe Care and Support

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

A fire door was held open using a piece of wood as the battery needed to be replaced.

Action Required:

Under Regulation 32 (1) (a) you are required to: Take adequate precautions against the risk of fire, including the provision of suitable fire equipment.

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

The battery can only be changed at 12noon and it was replaced on the 28th February 2014. In future when the battery needs changing the door will not be held open. Batteries and instructions on how to change them are left out for the staff.

Proposed Timescale: 28/02/2014

Theme: Safe Care and Support

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

The person who takes charge in the event of a fire was not clear.

Action Required:

Under Regulation 32 (1) (c) (iii) you are required to: Make adequate arrangements for the evacuation, in the event of fire, of all people in the designated centre and the safe placement of residents.

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

The Fire Policy will be updated to give clear guidelines on who takes charge in the event of a fire.

Proposed Timescale: 30/04/2014

Theme: Safe Care and Support

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

There was no learning identified following fire drills nor were fire drills adjusted to reflect the experience at previous fire drills.

Action Required:

Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire

practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

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

It is our current practice to hold a discussion immediately after each fire drill with the staff who took part in the drill. A report is written by the Person in Charge and staff write their comments.

Going forward, the report will be expanded to include learning outcomes. Future fire drills will be adjusted to reflect this.

Proposed Timescale: 30/05/2014

Theme: Safe Care and Support

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

One staff member did not have training in fire prevention.

Action Required:

Under Regulation 32 (1) (d) you are required to: Provide suitable training for staff in fire prevention.

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

Fire safety training was held on the 8th March 2014.

Proposed Timescale: 08/03/2014

Theme: Safe Care and Support

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

The external gate of the enclosed garden was locked and the key was stored in the office.

Action Required:

Under Regulation 32 (1) (b) you are required to: Provide adequate means of escape in the event of fire.

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

New coded locks have been applied to the external gates.

Proposed Timescale: 18/04/2014

Outcome 08: Medication Management

Theme: Safe Care and Support

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

The medication management policy was not signed or dated.

There was no policy on self medication.

There was no date of discontinuation of medication on prescription sheets.

Times and days medication is to be administered was not clear on prescription sheets.

In some cases medication was administered at a different time than the time detailed on the prescription sheet.

There was no maximum dose of PRN (as required) medication on some prescription sheets.

A discontinued food supplement was recorded as administered for three days after discontinuation date.

A prescribed food supplement was not recorded as administered for 24 days after date of prescription.

There were two PRN (as required) medications prescribed for one resident for the same reason and the drug prescription sheet did not detail which medication was to be used nor did it give sufficient detail regarding when the medication was to be used.

One medication stored in the medication fridge did not have a label detailing to whom it belonged.

Staff spoken with were not familiar with best practice guidelines relating to medication management.

Action Required:

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

The Medication Policy is signed and dated.

A Policy on Self Medication is now in place.

A weekly medication chart check-list has been introduced to ensure all documentation is correct.

The two PRN medications prescribed for one resident has now been changed to one PRN medication and it indicates when the medication is to be used.

The Pharmacy have been asked to label all medication on the box and contents. Staff spoken with on the day of inspection have up to date medication management training.

Proposed Timescale: 14/04/2014

Theme: Safe Care and Support

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

The medication of a resident deceased in 2012 was in the controlled drugs press.

Discontinued medication for one resident was stored in the controlled drugs press.

Action Required:

Under Regulation 33 (2) you are required to: Put in place suitable arrangements and appropriate procedures and written policies in accordance with current regulations, guidelines and legislation for the handling and disposal of unused or out of date medicines and ensure staff are familiar with such procedures and policies.

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

All controlled drugs not in use on the day of inspection have been returned to the pharmacy.

Going forward, no discontinued controlled drugs will be held in the Nursing Home.

Proposed Timescale: 04/03/2014

Outcome 10: Reviewing and improving the quality and safety of care

Theme: Effective Care and Support

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

The inspector was not satisfied of the validity of the medication audits as the audits did not identify issues which the inspector identified during the inspection.

Action Required:

Under Regulation 35 (1) (a) you are required to: Establish and maintain a system for reviewing the quality and safety of care provided to, and the quality of life of, residents in the designated centre at appropriate intervals.

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

Following the inspection, a meeting was held with the Pharmacy to discuss the inspectors' findings. A new comprehensive audit was carried out by the Pharmacist on the 21st March 2014. Going forward, this audit will be conducted every three months. The Person in Charge will carry out 3 monthly Medication Management Audits. The Assistant Director of Nursing will carry out Medication Management Competency Assessments Drug Round Audits as per our Medication Policy.

Proposed Timescale: 21/03/2014

Theme: Effective Care and Support

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

There was no evidence that any learning from medication audits was disseminated to staff nurses.

Action Required:

Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

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

Audit reports will be circulated to all Nurses and discussed at staff meetings.

Proposed Timescale: 30/05/2014

Outcome 11: Health and Social Care Needs

Theme: Effective Care and Support

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

Some care plans were signed by the next of kin rather than the resident and the reason for this was not recorded.

Action Required:

Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

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

The Residents file has been updated to include a section on who is responsible for signing the care plan and the reason why.

Proposed Timescale: 24/04/2014

Theme: Effective Care and Support

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

Some care plans did not sufficiently detail the resident's needs.

There was no evidence to indicate alternatives to restraint had been tried.

Missing persons profiles were not sufficiently detailed.

Action Required:

Under Regulation 8 (1) you are required to: Set out each resident's needs in an individual care plan developed and agreed with the resident.

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

The Personal Care Assessment addresses the residents preference in relation to a shower/bath and a Care Plan is written based on this assessment.

Some residents have bedrails in place for 5+ years and many use them as enablers. All admissions have a fall risk assessment carried out and based on the findings measures are put in place to help safeguard the resident. As a result of these assessments we have low beds and crash mats and sensor mats in place.

Missing Person Profiles will be updated as part of the three monthly reviews.

Proposed Timescale: 02/07/2014

Outcome 12: Safe and Suitable Premises

Theme: Effective Care and Support

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

Screening around beds was not adequate.

Action Required:

Under Regulation 19 (3) (e) part 2 you are required to: Provide adequate private accommodation for residents.

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

A supplier has been sourced.

Proposed Timescale: 30/06/2014

Theme: Effective Care and Support

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

Assistive equipment was stored in the hairdressing room.

Action Required:

Under Regulation 19 (3) (l) you are required to: Ensure suitable provision for storage of equipment in the designated centre

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

An alternative room is now in use for the storage of assistive equipment.

Proposed Timescale: 07/03/2014

Theme: Effective Care and Support

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

Radiators were too hot to the touch.

Action Required:

Under Regulation 19 (3) (j) part 1 you are required to: Provide sufficient numbers of toilets, and wash-basins, baths and showers fitted with a hot and cold water supply, which incorporates thermostatic control valves or other suitable anti-scalding protection, at appropriate places in the premises.

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

Thermostatic control valves are in place. The heating temperature has been adjusted.

Proposed Timescale: 14/03/2014

Theme: Effective Care and Support

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

The seating in the oratory was not suitable for residents' needs.

Action Required:

Under Regulation 19 (3) (h) you are required to: Provide suitable communal space for residents for the provision of social, cultural and religious activities appropriate to the circumstances of the residents.

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

The seating in the oratory has been changed and is now appropriate to the resident's needs.

Proposed Timescale: 03/03/2014

Theme: Effective Care and Support

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

The garden is not easily accessible by residents.

Action Required:

Under Regulation 19 (3) (o) you are required to: Provide and maintain external grounds which are suitable for, and safe for use by residents.

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

A key pad system will be installed and staff will be shown how to use it.

Proposed Timescale: 30/05/2014

Outcome 15: Food and Nutrition

Theme: Person-centred care and support

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

Policy on nutrition is insufficient to guide practice in relation to the prevention of dehydration.

Action Required:

Under Regulation 20 (7) you are required to: Implement a comprehensive policy and guidelines for the monitoring and documentation of residents nutritional intake.

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

There is a Hydration Policy in place that details the signs and symptoms of dehydration and guides practice in the prevention of dehydration.

Proposed Timescale: 12/03/2014

Outcome 18: Suitable Staffing

Theme: Workforce

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

Some staff files did not have Garda vetting, a full employment history and three references.

Action Required:

Under Regulation 18 (2) (a) and (b) you are required to: Put in place recruitment procedures to ensure no staff member is employed unless the person is fit to work at the designated centre and full and satisfactory information and documents specified in Schedule 2 have been obtained in respect of each person.

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

A staff file audit will be carried out to ensure all staff have three written references and Garda Vetting. All new staff will have any gaps in their employment checked and documented.

Proposed Timescale: 02/07/2014