

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Athlunkard House Nursing Home
<b>Centre ID:</b>	OSV-0000729
<b>Centre address:</b>	Athlunkard, Westbury, Clare.
<b>Telephone number:</b>	061 345 150
<b>Email address:</b>	info@athlunkardnh.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Killure Bridge Nursing Home Partnership
<b>Provider Nominee:</b>	Patricia McCarthy
<b>Lead inspector:</b>	Mary Costelloe
<b>Support inspector(s):</b>	Geraldine Ryan;
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	97
<b>Number of vacancies on the date of inspection:</b>	6

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 20 January 2015 10:00 To: 20 January 2015 19:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This report sets out the findings of an inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to vary conditions of registration. This inspection was unannounced and took place on one day. As part of the inspection the inspectors met with residents and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures.

The inspectors had serious concerns that medication management practices were not robust and posed a risk to residents. These issues of concern were brought to the attention of the provider/person in charge on the day of inspection, an immediate action plan was issued following the inspection.

While there were systems in place to review some aspects of the safety and quality of care, the inspectors were concerned that there were inadequate governance arrangements in place to maintain oversight of all departments including medication management, clinical assessment and care, risk management, staff training, house keeping/cleaning and infection control.

The provider advised inspectors the day following the inspection of the immediate actions she had taken to address the medication management issues and further actions she proposed to take to address other issues identified on inspection.

The provider had applied to vary the conditions of registration, to increase the number of beds by four in two single and one shared bedroom. The two new proposed single bedrooms did not meet the requirements of the Regulations and standards. The proposed new shared bedroom was not suitable as a shared room due to its layout options.

On the day of inspection, the inspectors observed sufficient staffing and skill mix on duty.

The communal areas were appropriately furnished and the décor was pleasant.

The collective feedback from residents was one of satisfaction with the service and care provided.

The areas for improvement are contained in the Action Plan at the end of this report.

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

***Outcome 01: Statement of Purpose***

***There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.***

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

The inspectors reviewed the statement of purpose submitted with the application to vary conditions. It did not accurately reflect the number of beds in the centre. The inspectors noted that some of the objectives set out in the statement of purpose were not always reflected in practice such as adherence to best practice policies.

**Judgment:**

Non Compliant - Moderate

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

While there were systems in place to review some aspects of the safety and quality of care, the inspectors were concerned that there were inadequate governance arrangements in place to maintain oversight of all departments including medication management, clinical assessment and care, risk management, staff training,

housekeeping/cleaning and infection control to ensure the service is safe, appropriate to the residents needs, consistent and effectively monitored. These areas are discussed further under outcomes 7, 8, 9, 11, 12 and 18.

The provider /person in charge advised inspectors the day following the inspection that the person in charge from another nursing home owned by the company was being employed in this centre to directly support the person in charge for the next three to four weeks while they were actively recruiting for the post.

**Judgment:**  
Non Compliant - Major

***Outcome 04: Suitable Person in Charge***  
***The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.***

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The Authority was notified of the absence of the person in charge in September 2014. The provider nominee has taken on the role of the person in charge since then. The person in charge is a registered nurse with the required experience in the area of nursing older people. She worked full time. She was on-call at weekends and out-of-hours.

The person in charge had undertaken a post graduate certificate in gerontology nursing and had recently completed a 'Train the trainer' FETAC (Further Education Training Awards Council) Level 6 course.

Deputising arrangements were in place in the absence of the person in charge. There was an on-call out of hours system in place.

**Judgment:**  
Compliant

***Outcome 05: Documentation to be kept at a designated centre***  
***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspectors had concerns that some of the records required under Schedule 3 of the Regulations were not maintained in a manner so as to ensure completeness and accuracy.

There was evidence that medications prescribed by the general practitioner (GP) were not being administered to residents. A number of medication administration charts reviewed reflected that a number of medications were not administered to residents with no rationale given for the non-administration.

There was evidence that medications were not administered at the times prescribed by the GP.

While there were written policies and procedures (Schedule 5), some of the policies were not implemented in practice, such as medication management, infection control, managing behaviours that challenge and smoking policies. The policy on use of restraint had not been updated to reflect best practice. Some staff were not familiar with some policies.

These are discussed further under outcomes 7 safeguarding and safety, 9 Medication management, 8 health and safety and 11 health and social care needs.

**Judgment:**

Non Compliant - Major

***Outcome 07: Safeguarding and Safety***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

While the inspectors found that measures were in place to protect residents from being harmed or abused, improvements were required to the management of residents' personal finances, restraint and behaviours that challenge.

There were policies on preventing and responding to allegations or suspicions of abuse. Staff spoken with were knowledgeable regarding their responsibilities. Staff spoken with and training records viewed confirmed that staff had received ongoing education on elder abuse.

There was a system in place for the management of residents' finances. The person in charge kept small amounts of money for safe keeping on behalf of some residents. The inspector saw that this was securely stored and balances checked were correct. Deposits and withdrawals were witnessed and signed by two people. Receipts were generally kept for all purchases but two receipts could not be located at the time of inspection. An inspector also noted that an envelope containing money with a residents name on it in one of the controlled drugs cupboards. There were no signatures/receipts to indicate what this money had been used for and the amount recorded on the outside of the envelope did not balance with the amount of money in the envelope. This was contrary to policy in the centre.

All residents had access to a secure lockable locker in their bedrooms should they wish to securely store any personal items.

The inspector reviewed the policy on behavioural management but noted that policy was not reflected in practice. Some staff spoken with told the inspector that they were unaware of the policy. The policy outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged and included guidance on assessment and monitoring of behaviours. Inspectors reviewed the files of residents presenting with behaviours that challenged and noted that there were no assessments completed and episodes of behaviour were not logged using the ABC monitoring chart in line with the policy. Care plans were in place but the information was limited; plans did not clearly guide and direct staff. Staff spoken with were knowledgeable regarding de-escalation techniques used but these were not reflected in the care plans. Staff spoken with and training records reviewed indicated

that staff had not received training on the management of behaviours that challenge.

The inspector reviewed the policy on the use of restraint and found that it required updating to reflect best practice and the national policy. Nursing staff spoken with told the inspector that she was not aware of the national policy and had not received training on the management of same.

The inspector reviewed a number of files of residents using bedrails. The numbers of residents using bedrails had decreased since the previous inspection, a restraint register was maintained, hourly checks were carried out and recorded on residents using bedrails and consent was documented. While risk assessments for the use of restraint had been completed and care plans were in place, they were not reflective of national policy. The assessment tool in use did not include other alternatives tried or considered. There was no multidisciplinary input into the decision making process prior to using bed rails.

**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):**

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

**Findings:**

While the provider had some systems in place to protect the health and safety of residents, staff and visitors, the inspectors had concerns that systems in place to manage infection control were inadequate and a number of risks were also identified. Learning/recommendations put in place following an incident involving a hoist had not been fully implemented.

There was a health and safety statement and risk management policy available. An inspector reviewed the risk register and found that it had been last updated in September 2014. Risks specifically mentioned in the Regulations such as assault, accidental injury, aggression and violence and self harm were included. The inspector saw from minutes of staff meetings that health and safety issues had been discussed at staff meetings.

On the day of inspection the inspectors noted a number of potential risks to residents, staff and visitors including

- a fire extinguisher placed on the floor of a ground floor bedroom corridor
- the door to the ground floor kitchen cleaners room was unlocked

- the door to the laundry room was unlocked
- unlabelled cleaning products were stored on the cleaners trolley
- the door to the ground floor kitchenette was unlocked
- free standing electric heaters were in use in some bedrooms.

While some of the above risks had been risk assessed, the control measures in place such as key coded pads to doors were not in working order. Other risks such as the use of electric heaters had not been risk assessed.

The inspectors reviewed the file of a resident who sustained an injury while using a hoist. The inspectors were concerned that recommendations put in place following the incident had not been fully implemented. While the resident had been reviewed by the physiotherapist following the incident and recommendations made regarding the type of hoist, size and colour of sling straps to be used, this information was not updated or referenced in the care plan. The care plan was updated a number of months later and the inspector noted that the information regarding the colour of hoist straps to be used for this resident were contrary to the physiotherapists recommendations. Staff spoken with confirmed that they had received updated training on the use of hoists and types of slings to be used. Staff informed the inspector that laminated cards with details of type, size and colour of sling straps to be used for individual residents had been attached to hoists to ensure that staff used the correct hoist and sling. The inspector noted that three hoists in use did not have this information as described by staff attached. This posed a risk to residents.

There was a site-specific emergency plan in place. The plan included clear guidance for staff in the event of a wide range of emergencies. Arrangements were in place locally for alternative accommodation in the event of the building having to be evacuated.

An inspector reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in July 2014 and the fire alarm was serviced on a quarterly basis. The last fire alarm service took place on 26 September 2014. Systems were in place for regular testing of the fire alarm, daily and weekly fire safety checks and these checks were being recorded. Fire safety training took place annually and included evacuation procedures and use of fire equipment. Staff spoken to told the inspector that they had received recent fire safety training. Training records reviewed indicated that staff had received up-to-date formal fire safety training.

A designated smoking room was provided for residents on the ground floor. The inspectors did not see evidence of smoking aprons being available to residents in the smoking room contrary to the centres own smoking policy.

Training records reviewed indicated that all staff members had received up-to-date training in moving and handling. Staff spoken to confirmed that they had received training.

The inspectors had concerns regarding infection control practices and cleaning practices. The inspectors observed that many areas and equipment in the centre were not maintained in a clean condition. There was no comprehensive documented cleaning policy/programme. Household/cleaning staff had not received adequate training and

staff had not been certified as competent contrary to the centres own infection control policy.

The upholstery to many dining room chairs were encrusted with food debris, many areas of the dining room including behind and underneath of equipment, inside of equipment such as refrigerators, bain marie and storage units showed obvious lack of regular cleaning.

Stained cutlery was observed in the cutlery container.

Other equipment including raised toilet seat, shower chairs, hoists and bath were not thoroughly cleaned.

The ground floor kitchenette including the floor and table were stained and dirty.

The extract fans to many toilet/shower rooms had accumulations of dust evident.

The laundry room was maintained in an unclean condition with a build up of dirt evident behind equipment, at wall floor junctions and underneath the sink unit.

The provider/person in charge advised the inspectors the day following the inspection that a cleaning policy had been put in place, cleaning procedures were being drafted for all areas and that many areas had been deep cleaned.

**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:**

The inspectors had serious concerns that medication management practices were not robust and posed a risk to residents. These issues of concern were brought to the attention of the provider/person in charge on the day of inspection, an immediate action plan was issued following the inspection.

There was a comprehensive medication management policy in place but this was not implemented in practice.

The policy on administration of medications from a blister pack system referred to

administering medications as per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management. The centre was not concurring with its own policy on medication management.

There was evidence that the practices regarding the safeguarding of medications requiring strict controls were in need of immediate review. In particular, the foil blister pack containing a medication requiring strict control was damaged and two tablets appeared crushed. The person in charge and staff nurses were unable to clarify the medication contained in the foil blister pack.

Transcription of medication was not as per the centre's policy where it was stated that all transcribed medications had to be signed and dated by two staff nurses and reviewed by the GP within a specific timeframe. Of a sample of medication prescription charts reviewed findings included:

- some medications transcribed by the staff nurse/nurses had no dosage indicated
- some transcribed medications had no signatures of the transcribing nurses
- some transcribed medications had one signature of the transcribing nurse
- transcribed medications were not dated and it was unclear when the GPs reviewed the medications transcribed by the staff nurse/nurses.

There was evidence that the maximum dose of medications prescribed on an as required basis (PRN) was not documented for some transcribed medications.

There was evidence that medications prescribed to commence for one resident on the 16 January 2015 were recorded for November 2014.

Medications discontinued by the GPs were not dated or signed.

Medications that staff stated were administered as crushed to a resident were not prescribed for administration in a crushed format.

One resident had two medication prescription charts for medications prescribed PRN. Three medications discontinued on one chart, were prescribed to be administered on the second chart. Staff were unclear as to which chart was to be used.

There was no information on a resident's administration chart that the resident had an allergy to a particular medication.

Two tubes of a topical gel and one tube of an antibiotic cream were not identified with the residents' name for whom they were prescribed.

Incorrect doses of medications, as prescribed by the GPs on the residents' prescription chart were administered to residents. For example, one medication was prescribed to be administered four times a day (QDS). There was evidence that this medication was given once a day for six days in December 2014 and was not administered on one day in January 2015. Another medication (analgesia) was prescribed to be administered three times a day. There was evidence that this medication was not administered as prescribed.

**Judgment:**  
Non Compliant - Major

**Outcome 10: Notification of Incidents**  
*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**  
Safe care and support

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

**Findings:**  
The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. Notifications as required had been notified to the Chief Inspector in the past.

An incident involving a resident who required immediate medical attention was not notified to the Chief Inspector within the required time frame. The incident was later notified to the Authority following enquiries being made by the inspector.

The inspector reviewed the incident log and noted that records were maintained of all incidents that took place in the centre.

**Judgment:**  
Non Compliant - Moderate

**Outcome 11: Health and Social Care Needs**  
*Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**  
Effective care and support

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

**Findings:**  
The inspectors had concerns that the nutritional needs of a resident were not being met and that nursing documentation including clinical risk assessments and care plans did

not always clearly guide staff. Residents had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

All residents had access to GP services. There was an out-of-hours service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services and psychiatry of later life. Chiropody and optical services were also provided. The inspector reviewed residents' records and found that residents had been referred to these services and recommendations were on file, however, residents care plans had not always been updated to reflect these recommendations. This is discussed further under outcome 8.

Inspectors reviewed a sample of residents files including the files of residents with nutritional needs, weight loss, using restraint, presenting with challenging behaviour and at high risk of falls.

The management of restraint and challenging behaviour are discussed under outcome 7.

While there was a range of clinical risk assessments in place, the inspectors noted that some assessments did not concur with one another for example:

- an assessment of a resident's activity of daily living (ADL) stated that the resident had a high dependency however low dependency was noted on the resident's assessment
- a resident's mobility was assessed as being independent however another assessment stated that the resident required the assistance of one staff. Staff stated that the resident required the assistance of staff and was assessed with a high risk of falls
- another resident's comprehensive assessment stated that the resident required the assistance of two staff while the resident's manual handling assessment did not have this information
- one resident's assessment stated that the resident was continent; however another assessment stated that the resident had occasional accidents ( bladder and bowel).

Some risk assessments were duplicated on different templates such as falls risks.

There were no assessments completed for residents who presented with behaviours that challenged.

Inspectors noted that care plans were not in place for all identified issues. Other care plans in place were not informative and did not clearly guide the care of the resident. Some care plans had not been updated following assessment and recommendations of allied health professionals such as the physiotherapist or the dietician. Residents' care planning did not clearly identify the rationale for the care plan; the intervention in place to address the problem or the goal/outcome.

The inspectors had concerns that residents weight changes were not closely monitored. A resident with a significant loss of weight loss (15kgs) over a six month period did not have a care plan to address the weight loss or information to guide and inform staff on

how to manage the resident's care in this matter. The instructions arising from the resident's dietetic review and assessment carried out in September 2014 and October 2014 had not been adhered to or put into place.

The clinical assessment tool used by staff to assess the resident's risk of malnutrition; the malnutrition universal screening tool (MUST), indicated that the resident, with a significant weight loss, was at a low risk of malnutrition.

A sheet in the chart of the resident with a significant weight loss titled 'dietary requirement' had no reference with regard to the resident's weight loss.

The inspectors noted that residents at high risk of falls were generally being well managed. There was evidence that falls risk assessments and falls care plans in place were updated post falls. Additional measures including low low beds, alarm mats and crash mats had been put in place for some residents. A monthly falls audit was being completed and the reduction in the number of falls continued. All residents were assessed by the physiotherapist post falls. There was a falls warden appointed on each floor to ensure all residents were checked regularly and to ensure all equipment was in working order.

**Judgment:**  
Non Compliant - Major

***Outcome 12: Safe and Suitable Premises***

***The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**  
Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

While the centre was purpose-built and nicely decorated, the inspectors had concerns that some parts of the building and some equipment were not maintained in a clean condition, cleaning and infection control are discussed further under outcome 8. Suitable heating was not provided for all residents at the time of inspection.

The provider acknowledged that there was an issue with the under floor heating system. He stated that they were currently working with a consultant in trying to resolve the issue. Staff informed the inspector that they were unable to control the temperature and had no access to thermostats, there were no thermostat controls in residents' bedrooms.

The inspectors heard relatives complaining of the cold in some bedrooms. Residents complained that the ground floor smoking room was cold and inspectors noted same. Nursing staff confirmed that the heating was not working in some zones while other zones were too warm. Free standing electric heaters had been provided to some bedrooms. The inspectors had concerns that these posed a risk to residents. This is discussed further under outcome 8 Health and Safety.

The provider had applied to vary the conditions of registration, to increase the number of beds by four using two single and one shared bedroom. The two new proposed single bedrooms did not meet the requirements of the Regulations and standards as they did not have en suite facilities. The proposed new shared bedroom did not meet the requirements as a shared room due to its layout options. The provision of privacy screening in the shared rooms was inadequate.

The circulation areas had hand rails, corridors were wide and allowed plenty of space for residents walking with frames and using wheelchairs. A lift was provided between floors.

There was a variety of communal day spaces including day rooms, dining rooms and smoking rooms on each floor. The communal areas had a variety of comfortable furnishings and were domestic in nature.

There were adequate numbers of assisted toilets located adjacent to the day room areas. There was an assisted bathroom with specialised bath and assisted shower for residents use.

Other than the proposed two new single bedrooms, all bedrooms had en suite bathroom facilities. There were call-bell facilities, specialised beds and screening curtains in shared rooms. Residents were encouraged to personalise their rooms and many had photographs and other personal belongings in their bedrooms. The inspectors noted that there was only one chair provided in a shared room and the bed side locker could not be placed beside the bed because of the layout of the room.

Separate staff changing, toilet and dining facilities were provided, the cistern cover to the ground floor WC was ill fitting.

There were two enclosed landscaped gardens which could be accessed directly from the ground floor day areas.

Inspectors found that the building was secure. The main entrance door was fitted with an automatic locking system. CCTV cameras were in operation on the front entrance area, external areas and main corridors in order to provide additional security. An electronic bracelet system was in place for residents assessed as being at high risk of absconsion.

**Judgment:**  
Non Compliant - Major

**Outcome 13: Complaints procedures**

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

There was a complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints policy had been updated following the last inspection to include the name of the designated person to ensure that all records relating to complaints were maintained and all complaints were appropriately responded to. The name of the complaints officer had been updated following the change of the person in charge but the name of the designated person to ensure that all records relating to complaints were maintained and all complaints were appropriately responded to had not been updated. The complaints procedure was clearly displayed and contained all information as required by the Regulations including the name of the complaints officer and details of the appeals process.

**Judgment:**

Non Compliant - Minor

**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

**Findings:**

The person in charge told the inspectors that the staffing levels and skill mix were based on the assessed needs and dependency levels of residents. The inspectors had concerns that some clinical risk assessments used to determine the dependency levels of residents were inaccurate and did not concur with other assessments. For example a resident assessed as low dependency required the assistance of two staff to mobilise. The provider /person in charge advised inspectors the day following the inspection that

assessments would be reviewed before the weekend and staffing re-assessed accordingly.

Inspectors noted adequate numbers and skill mix of staff on duty at the time of inspection. On the day there were 97 residents living in the centre, two residents were in hospital. At the time of inspection there were four nurses and fourteen care staff on duty in the morning. There were three nurses and seven care staff on duty up until 22.00 hours and three nurses and five care staff on duty at night time. During the night time there was one nurse allocated to each floor and the third nurse was available to assist on either floor. The person in charge was normally on duty during the day time. There was a supernumery CNM on duty for six hours three days a week.

The management continued to provide training to staff. Training records reviewed indicated that training had taken place during 2014 on falls management, incontinence, dysphagia and more recently infection control. Some nursing staff had training in cardiac prevention resuscitation CPR, wound management, palliative care and vena puncture. There was a training plan in place for 2015. Staff had not received up to date training on medication management, care planning, management of restraint and behaviours that challenge.

Staffing files were not reviewed on this inspection.

**Judgment:**  
Non Compliant - Moderate

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### **Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### ***Report Compiled by:***

Mary Costelloe  
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>	Athlunkard House Nursing Home
<b>Centre ID:</b>	OSV-0000729
<b>Date of inspection:</b>	20/01/2015
<b>Date of response:</b>	11/02/2015

### Requirements

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

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

### Outcome 01: Statement of Purpose

#### Theme:

Governance, Leadership and Management

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

The statement of purpose did not accurately reflect the number of beds in the centre. Some of the objectives set out in the statement of purpose were not always reflected in practice such as adherence to best practice policies.

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

**Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

Statement of Purpose has been updated to reflect bed capacity and has been submitted to the authority.

**Proposed Timescale:** 02/03/2015

**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:**

There were inadequate governance arrangements in place to maintain oversight of all departments including medication management, clinical assessment and care, risk management, staff training, housekeeping/cleaning and infection control to ensure the service is safe, appropriate to the residents needs, consistent and effectively monitored.

**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:**

Person In Charge post has been filled, she is supported in this role by the provider and three clinical nurse managers

**Proposed Timescale:** 02/03/2015

**Outcome 05: Documentation to be kept at a designated centre****Theme:**

Governance, Leadership and Management

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

Policies such as medication management, infection control, managing behaviours that challenge and smoking were not implemented in practice. The policy on use of restraint had not been updated to reflect best practice. Some staff were not familiar with some policies.

**Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Medication management training has been delivered, further sessions are being scheduled to ensure all nurses have received training before end of February. Restraint Policy has been updated and all assessments are in line with updated policy. Staff training will be complete by end of February. Infection control training will be complete by end of February. The centres smoking policy is in place and adhered to.

Management of behaviours that challenge is in line with the centres policy. Training in this area will be completed by end of April

**Proposed Timescale:** 30/04/2015

**Theme:**

Governance, Leadership and Management

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

There was evidence that medications prescribed by the general practitioner (GP) were not being administered to residents. A number of medication administration charts reviewed reflected that a number of medications were not administered to residents with no rationale given for the non-administration.

There was evidence that medications were not administered at the times prescribed by the GP.

**Action Required:**

Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

All medication charts identified have been reviewed. All prescribed medications are being given to residents.

In conjunction with the Nursing Staff and the Pharmacist the newly appointed Person in Charge is undertaking a comprehensive review of all aspects of medication management. An action plan (to involve all relevant stakeholders) is being put in place to ensure that the Centre will comply with local policy and the statutory requirements of medication management. This will ensure that drug prescription charts are kept up to date, ensuring evidence of rationale for residents not receiving medication is clear and ensuring medications no longer prescribed are discontinued in line with current prescription.

**Proposed Timescale:** 02/03/2015

## Outcome 07: Safeguarding and Safety

### Theme:

Safe care and support

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

The policy on behavioural management was not reflected in practice. Some staff spoken told the inspector that they were unaware of the policy.

There were no assessments completed and episodes of behaviour were not logged using the ABC monitoring chart in line with the policy.

Information provided in care plans was limited and they did not clearly guide and direct staff. Staff spoken with were knowledgeable regarding de-escalation techniques used but these were not reflected in the care plans.

Staff spoken with and training records reviewed indicated that staff had not received training on the management of behaviours that challenge.

### **Action Required:**

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

Staff are aware of policy on behaviour management.

The files of two residents with behaviours that challenge were viewed on day of inspection, one had ABC monitoring charts in line with policy. Triggers and de-escalation techniques were accurately documented and presented to the inspector. The other resident had a behaviour log which was contrary to the policy, ABC chart now in place, however challenging behaviour has resolved.

As per Training Plan for 2015 presented on day of inspection, training on dementia and behaviours that challenge is scheduled for March. This will include care planning so that care plans will be specific to meet the needs of individual residents with challenging behaviour

### **Proposed Timescale: 31/03/2015**

### Theme:

Safe care and support

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

The policy on the use of restraint required updating to reflect best practice and the national policy. Some nursing staff were not aware of the national policy and had not received training on the management of same.

Risk assessments for the use of restraint were not reflective of national policy. There was no multidisciplinary input into the decision making process prior to using bed rails.

**Action Required:**

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

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

The low level of bedrail use at the time of inspection clearly indicated a culture of awareness around alternatives to bedrails. The national policy on restraint was in place on day of inspection however this was not made available on the day. Evidence of multidisciplinary input is now formally documented. Training on Restraint Policy will be given to all relevant staff before end of February

**Proposed Timescale:** 28/02/2015

**Theme:**

Safe care and support

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

Some receipts for purchases made on behalf of residents could not be located at the time of inspection. An envelope containing money with a residents name on it was kept in one of the controlled drugs cupboards. There were no signatures/receipts to indicate what this money had been used for and the amount recorded on the outside of the envelop did not balance with the amount of money in the envelope. This was contrary to policy in the centre.

**Action Required:**

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

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

The once off occasion of holding a residents petty cash in the upstairs drug cupboard has been discontinued. Receipts will be held for all items purchased on behalf of residents such as cigarettes. Two signatures will be recorded for all transactions in line with our policy.

**Proposed Timescale:** 02/03/2015

**Outcome 08: Health and Safety and Risk Management**

**Theme:**

Safe care and support

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

Recommendations/learning put in place following a serious incident involving a hoist had not been fully implemented. The recommendations made by the physiotherapist following the incident regarding the type of hoist, size and colour of sling straps to be used was not used to inform/update or referenced in the care plan. The care plan was updated a number of months later with information regarding the colour of hoist straps to be used which was contrary to the colour of straps recommended by the physiotherapist. Staff informed the inspector that laminated cards with details of type, size and colour of sling straps to be used for individual residents had been attached to hoists to ensure that staff used the correct hoist and sling. Three hoists in use did not have this information as described by staff attached. This posed a risk to residents.

**Action Required:**

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The care plan for the resident involved in an incident with the hoist has been updated. Recommendations from the physiotherapist are referenced in her care plan. Laminate cards are on all hoists indicating type and size of sling and colour hook to be used for each resident.

Additional clinical governance will facilitate each manager to monitor instructions given from multi disciplinary team and ensure accurately reflecting care plans are put in place. This will ensure incidents are promptly identified and investigated, accurate follow through will lead to learning from incidents.

**Proposed Timescale:** 02/03/2015

**Theme:**

Safe care and support

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

On the day of inspection the inspectors noted a number of potential risks to residents, staff and visitors including

- a fire extinguisher placed on the floor of a ground floor bedroom corridor
- the door to the ground floor kitchen cleaners room was unlocked
- the door to the laundry room was unlocked
- unlabelled cleaning products were stored on the cleaners trolley
- the door to the ground floor kitchenette was unlocked
- free standing electric heaters were in use in some bedrooms.

While some of the above risks had been risk assessed, the control measures in place such as key coded pads to doors were not in working order. Other risks such as the use of electric heaters had not been risk assessed.

**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:**

All fire extinguishers are wall mounted. A lock has been fitted on ground floor kitchen cleaners room. Laundry staff have been instructed to ensure code lock is engaged at all times. Ground floor kitchenette has no risk equipment. All residents with free standing radiator heaters have been risk assessed. All products on cleaners trolleys are labelled

**Proposed Timescale:** 02/03/2015

**Theme:**

Safe care and support

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

Many areas and equipment in the centre were not maintained in a clean condition. There was no comprehensive documented cleaning policy/programme. Household/cleaning staff had not received adequate training and staff had not been certified as competent contrary to the centres own infection control policy.

The upholstery on many dining room chairs were encrusted with food debris, many areas of the dining room including behind and underneath of equipment, inside of equipment such as refrigerators, bain marie and storage units showed obvious lack of regular cleaning.

Stained cutlery was observed in the cutlery container.

Other equipment including raised toilet seat, shower chairs, hoists and bath were not thoroughly cleaned.

The ground floor kitchenette including the floor and table were stained and dirty.

The extract fans to many toilet/shower rooms had accumulations of dust evident.

The laundry room was maintained in an unclean condition with a build up of dirt evident behind equipment, at wall floor junctions and underneath the sink unit.

**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:**

A Cleaning Policy has been put in place. Schedules and procedures cover all areas including medical equipment. All household/cleaning staff will receive training and be certified competent in use of products and procedures before end of February. Deep cleaning has taken place in identified areas such as kitchenettes, dining room and laundry. Stained dining room chairs have been steam cleaned and a programme of maintenance put in place. Extraction fans in toilets/shower rooms have been cleaned. Medical equipment and food storage equipment have also been deep cleaned. Regular audits will highlight deficiencies in hygiene standards

**Proposed Timescale:** 28/02/2015

**Theme:**

Safe care and support

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

Smoking aprons were not available to residents in the smoking room contrary to the centres own smoking policy and posing a risk to residents.

**Action Required:**

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Smoking aprons are available for residents use in smoking rooms.

**Proposed Timescale:** 02/03/2015

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

Not having in place appropriate, suitable and safe practices regarding the administration of medicines to residents.

The centre's policy on administration of medications from a blister pack system refers to administering medications as per An Bord Altranais agus Cnáimhseachais Guidelines to nurses and midwives on medication management. The centre is not concurring with its own policy on medication management.

There was evidence that the practices regarding the safeguarding of medications requiring strict controls were in need of immediate review. In particular, the foil blister

pack containing a medication requiring strict control was damaged and two tablets appeared crushed. The person in charge and staff nurses were unable to clarify the medication contained in the foil blister pack.

Transcription of medication was not as per the centre's policy where it was stated that all transcribed medications had to be signed and dated by two staff nurses and reviewed by the GP within a specific timeframe. Of a sample of medication prescription charts reviewed findings included:

- some medications transcribed by the staff nurse/nurses had no dosage indicated
- some transcribed medications had no signatures of the transcribing nurses
- some transcribed medications had one signature of the transcribing nurse
- transcribed medications were not dated and it was unclear when the GPs reviewed the medications transcribed by the staff nurse/nurses.

There was evidence that the maximum dose of medications prescribed on an as required basis (PRN) was not documented for some transcribed medications.

There was evidence that medications prescribed to commence for one resident on the 16 January 2015 were recorded for November 2014.

Medications discontinued by the GPs were not dated or signed.

Medications that staff stated were administered as crushed to a resident were not prescribed for administration in a crushed format.

One resident had two medication prescription charts for medications prescribed PRN. Three medications discontinued on one chart, were prescribed to be administered on the second chart. Staff were unclear as to which chart was to be used.

There was no information on a resident's administration chart that the resident had an allergy to a particular medication.

Two tubes of a topical gel and one tube of an antibiotic cream were not identified with the residents' name for whom they were prescribed.

Incorrect doses of medications, as prescribed by the GPs on the residents' prescription chart were administered to residents. For example, one medication was prescribed to be administered four times a day (QDS). There was evidence that this medication was given once a day for six days in December 2014 and was not administered on one day in January 2015. Another medication (analgesia) was prescribed to be administered three times a day. There was evidence that this medication was not administered as prescribed.

**Action Required:**

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

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

Medication management policy has been updated to reflect standard operating procedures.

A review of practices regarding the safeguarding of medications requiring strict control has taken place. All medications requiring strict control are counted by 2 nurses at end of each shift, all foil backed tablets are taken from boxes or plastic pockets to verify that blister is sealed.

All medications transcribed by nurses on charts reviewed by inspectors have dosages indicated with signatures of two transcribing nurses. All transcribed medications are dated and reviewed by GP within 24 hours. All PRN medications have maximum dosages indicated. All medicines that require crushing are signed by doctor on prescription chart. Medications discontinued are signed and dated by GP. All reviewed residents prescription charts are in line with GPs prescriptions. All known drug allergies are clearly indicated on Drug Prescription Charts. All tubes of topical gels are doubly labelled by pharmacist - box and tube.

All Drug Prescription Charts to be reviewed monthly by Clinical Nurse Manager in conjunction with renewal of Drug administration record from pharmacy. Any changes noted at this time to be transcribed and initialled by 2 nurses and signed by general practitioner within 72 hours ensuring Drug Prescription Chart accurately reflects current prescription.

Separate Drug Prescription Chart to exist for Regular Medications, Short Term Medications, PRN Medications and Faxed Prescriptions, all faxed prescriptions are charted and signed by general practitioner within 72 hours.

Separate PRN Medication Chart will facilitate audit of PRN Medications, this will inform the need to discontinue, chart regularly or introduce alternative. Maximum doses will be included for all PRN Medications and stop date for all short-term medications.

A system will be developed to ensure that all Drug Prescription Charts are re-written 3 monthly by general practitioner or sooner if indicated ie if a lot of alterations to medications occur in that three month period and chart becomes difficult to interpret. All staff currently receiving medication management training, this is centred around our Medication Management Policy

**Proposed Timescale:** 02/03/2015

**Outcome 10: Notification of Incidents**

**Theme:**

Safe care and support

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

An incident involving a resident who required immediate medical attention was not notified to the Chief Inspector within the required time frame.

**Action Required:**

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

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

All serious incidents will be notified to the chief inspector within 3 working days.

**Proposed Timescale:** 02/03/2015

**Outcome 11: Health and Social Care Needs****Theme:**

Effective care and support

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

A resident with a significant loss of weight loss (15kgs) over a six month period did not have a care plan to address the weight loss or information to guide and inform staff on how to manage the resident's care in this matter.

The instructions arising from the resident's dietetic review and assessment carried out in September 2014 and October 2014 had not been adhered to or put into place.

The clinical assessment tool used by staff to assess the resident; the malnutrition universal screening tool (MUST) indicated that the resident, with a significant weight loss, was at a low risk of malnutrition.

A sheet in the chart of the resident with a significant weight loss and titled 'dietary requirement' had no reference with regard to the resident's weight loss.

There was conflicting Information in residents' clinical risk assessments.

Residents' clinical risk assessments did not accurately inform the residents' care planning process.

**Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Care plan for resident with significant weight loss has been updated. MUST score has been updated. Dieticians recommendations have been implemented.

Training for nurses on weight loss screening has taken place.

**Proposed Timescale: 02/03/2015**

**Theme:**

Effective care and support

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

Care plans were not in place for all identified issues. Other care plans in place were not informative and did not clearly guide the care of the resident. Some care plans had not been updated following assessment and recommendations of allied health professionals such as the physiotherapist.

**Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

Care plans are in place for all identified issues of residents reviewed on day of inspection. All care plans of reviewed residents have been updated to reflect recommendations from allied health professionals.

Care plan training has taken place for all Clinical Nurse Managers plus one senior staff nurse, our Person In Charge has attended a study day on 'Care Plan in Residential Care Settings' Clinical Nurse Managers are engaging in one-to-one training sessions with junior nurses enhancing nurses knowledge thus ensuring all care plans are prepared and kept updated in line with Regulation 06(1).

**Proposed Timescale: 02/03/2015**

**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:**

Suitable heating was not provided for all residents at the time of inspection. There were no thermostat controls in residents' bedrooms. Some bedroom areas were cold. The ground floor smoking room was cold.

Areas of the building and some equipment were not maintained in a clean condition.

The cistern cover to the ground floor staff WC was ill fitting.

**Action Required:**

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

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

A heating consultant has been engaged who is in the process of putting forward a solution to resolve existing heating problem. Thermostatically controlled radiator type heaters are available for areas cooler than recommended temperature. All residents using these radiators are risk assessed.

All areas of the building and equipment are in a clean condition. A comprehensive cleaning programme has been put in place to include all areas of the home plus all equipment. The cistern cover to the ground floor staff WC has been replaced.

**Proposed Timescale:** 15/04/2015

**Outcome 13: Complaints procedures****Theme:**

Person-centred care and support

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

Update the name of the designated person to ensure that all records relating to complaints were maintained and all complaints were appropriately responded to had not been updated.

**Action Required:**

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The Complaints Policy has been updated

**Proposed Timescale:** 02/03/2015

**Outcome 18: Suitable Staffing****Theme:**

Workforce

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

Staff had not received up to date training on medication management, care planning, management of restraint and behaviours that challenge.

**Action Required:**

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

Medication management training has been delivered, further sessions are being scheduled to ensure all nurses have received training before end of February. Care plan training has taken place for all Clinical Nurse Managers plus one senior staff nurse, our Person In Charge has attended a study day on Care Planning in Residential Care Settings on 23/02/2015. Clinical Nurse Managers are engaging in one-to-one training sessions with junior nurses. Restraint training will be complete by end of February. Training on Behaviours that Challenge will be complete by end of April

**Proposed Timescale:** 30/04/2015