

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Lisdarn Centre for the Older Person
Centre ID:	OSV-0000490
Centre address:	Lisdarn Centre, Cavan.
Telephone number:	049 437 3190
Email address:	jenny.smyth@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Rose Mooney
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	32
Number of vacancies on the date of inspection:	4

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 April 2015 09:00	13 April 2015 17:15
14 April 2015 09:10	14 April 2015 15:00

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 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
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 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre.

The inspector met with the provider, person in charge and members of the management team who all displayed a good knowledge of the Authority's Standards and regulatory requirements. A number of questionnaires from residents and relatives were received prior to the inspection and the inspector spoke to residents during the inspection. They were proactive in their response to the actions required

from the previous inspection and the majority of matters identified were satisfactorily completed.

The inspector was satisfied that the residents nursing and care needs were being met. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Residents had good access to general practitioners (GP). The person in charge was fully involved in the management of the centre and was found to be easily accessible to residents, relatives and staff.

There were improvements in the system to ensure the health and safety of residents, staff and visitors. Residents spoken with stated that they felt safe in the centre. Questionnaires received from relatives further confirmed they feel their family member is safe.

As identified on previous inspections the physical environment does not comply with Regulation 17, Schedule 6 and the Authority's standards. Some remedial work and changes in practice have been undertaken to improve the quality of life for residents. However, the provider at the time of this inspection did not have in place scaled drawings with a costed plan to reconfigure multiple occupancy bedroom accommodation. This is required in accordance with the premises and physical environment regulatory notice and the National Quality Standards for Residential Care settings for Older People in Ireland.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of 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.

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):

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

Findings:

The statement of purpose set out the services and facilities provided in the designated centre and the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider and had been updated in April 2015.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a defined management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre. There was an organisational structure in place to support the person in charge which included three CNM 2 grades.

The HSE had appointed a person to the role of provider nominee who was suitably qualified and experienced to carry out the functions of the post. There were adequate

resources available including staffing and assistive equipment.

A range of clinical data was being collected weekly. This included information on the number of bedrails in use, any incidents of pressure wounds, any resident experiencing pain and any fall or serious injury sustained the number of residents on psychotropic medication and resident's weights.

However, a pro active auditing program was not established with key areas identified for review during 2015, with the aim to identify trends in the data collated with the objective of developing improvement plans to ensure enhanced individual outcomes for residents.

Monitoring systems require further development by the provider to ensure a more robust consistent approach in line with the requirements of regulation 23. An annual report on the quality and safety of care was not compiled for 2014 with copies made available to the residents or their representative for their information as required by the Regulations.

Judgment:

Substantially Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that each resident had an agreed written contract which included details of the services to be provided for that resident and the overall fees to be charged. The inspector reviewed a sample of three contract of care to include the contract for the resident mostly recently admitted to the centre. All contracts were signed by relevant parties.

The overall fee was noted on the contract. Charges payable per all items not included in the overall fee were outlined for all additional expenses incurred by residents clearly in the contract of care.

There was a residents' guide developed containing all the information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy, the services provided and the complaints procedure.

The complaints procedure, certificate of registration and Statement of Purpose was

displayed and available for visitors to view.

Judgment:

Compliant

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 person in charge is a registered nurse and holds a full-time post. She is knowledgeable of residents care needs. There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge and she is supported by a clinical nurse manager grade two.

The person in charge maintained her professional development and attended mandatory training required by the Regulations in fire evacuation, safe moving and handling of residents and adult protection. She had attended courses on end of life care and behaviours that challenge.

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):

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

Findings:

The inspector found that there were systems in place to maintain complete and accurate

records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner. Appropriate insurance cover was in place with regard to accidents and incidents, out sourced providers and residents' personal property.

The directory of residents was maintained electronically. This contained the facility to record all the information required by schedule three of the regulations and was maintained up to date. However, the details of the cause of death when established were not recorded in the directory of residents'.

A sample of five staff files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

On previous inspections the inspectors identified the layout of the recording of information in care plans required review. Previously it was difficult to track the most current review or most current risk assessment outcome as sheet were rewritten on and information was not clearly legible. A review of a selection of resident's care files identified risk assessments was well maintained and completed on a new assessment tool as required. The documentation was updated and there was clear linkage between the risk assessment outcomes and plans of care.

Judgment:

Substantially Compliant

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. There are key senior managers appointed to deputise while the person in charge was absent. To date this has occurred on one occasion.

Judgment:

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):

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

Findings:

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The policy was specific to the centre and revised since the last inspection as it was an area identified for improvement in the action plan. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse and the contact details of the HSE, senior case worker for adult protection were documented in the policy.

Residents spoken with stated that they felt safe in the centre and questionnaires received from relatives further confirmed they feel their family member is safe. There was a visitors log in place and entrance/exit door was secured. No incidents, allegations or suspicions of abuse have been recorded or notified to the Authority in the preceding 12 months at this centre.

Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector viewed records confirming staff had refresher training in protection of vulnerable adults and further training was planned for eight staff. Garda Síochána vetting had been applied for all staff members.

The financial controls in place to ensure the safeguarding of residents' finances were examined by the inspector. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions. A petty cash system was in place to manage small amounts of personal money held in safe keeping for some residents. A record of the handling of money was maintained for each transaction. Two signatures were recorded for each transaction. The ongoing balance was transparently managed.

There is a policy on the management of behaviour that is challenging and supportive strategies were in place. Where residents had specialist care needs such as mental health problems there was evidence in care plans of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum therapeutic values. This was evidenced by a review of

medical notes where reviews were detailed.

Staff spoken with were very familiar with resident's behaviours and could describe the particular interventions well to the inspector. The majority of staff had received training in behaviours that challenge in the past two months. Two staff members spoken with described the course and the new skills they had learned to assist then to respond appropriately in line with the centre's policy on the model of behaviour management utilised.

The policy on restraint was based on the national policy on promoting a restraint free environment. The inspector reviewed a sample of assessments that underpinned physical restraint practice (bed rails). Restraint measures in place included the use of bedrails by the majority of residents on the long stay unit. There was a risk assessment completed prior to the use of the restraint and assessments were regularly revised. Signed consent was obtained by the resident or their representative. There is multi disciplinary input in the decision making process. However, further work is required in exploring alternative options prior to using a restraint measures to promote a restraint free environment in line with the national policy.

Judgment:

Substantially Compliant

***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:

There were improvements in the system to ensure the health and safety of residents, staff and visitors. The actions in the previous inspection which related to risk, health and safety were mostly completed with some further minor improvements required. Each resident's moving and handling needs was identified and available to staff at the point of care delivery in bedrooms. The assessments outlined whether a resident required the assistance of a hoist, size of sling and type.

The risk management policy was revised to include the procedures and learning outcomes from incidents to minimise the risk of a repeat of a similar accident. Incidents were discussed at handover reports and staff meetings. The risk management policy contained the procedures required by regulation 26 and schedule 5 to guide staff.

One incident with a serious outcome for a resident occurred since the last inspection. This notifiable event was reported to the Authority as required by the Regulations at the

time of occurrence. An investigation report in line with the centre's policy was undertaken. Actions were implemented to both ensure the care and welfare of residents and learning for staff to minimise the risk of a similar accident.

The training records showed that the majority of staff had up-to-date training in moving and handling. Six staff were identified as requiring refresher training and a training date was arranged. There was sufficient moving and handling equipment available to staff to meet residents needs. There was a contract in place to ensure equipment was serviced and safe for use.

The fire policy was updated as required by the action plan of the previous inspection. The policy detailed the safety precautions in relation to piped and portable oxygen outlets in the event of a fire. The inspector read the records which showed that inspections of fire exits were undertaken daily. The fire alarm was sounded weekly and automatic door closer were checked to ensure they were operational. The fire extinguishers were checked to ensure equipment was in place and intact. The inspector viewed contracts which indicated the fire alarms; emergency lighting, smoke and heat detectors were checked and serviced routinely and fire extinguisher serviced annually. Evacuation sheets were fitted to the beds of all residents and the escape route plans were provided to indicate the direction to the nearest fire exit.

Fire training for staff was completed annually by an accredited trainer. The inspector reviewed the fire safety register and training records. Staff to whom the inspector spoke confirmed their attendance at fire training and gave accounts of their understanding of fire procedures in the event of an outbreak of fire. Since the last inspection a number of fire drills were undertaken to reinforce their theoretical knowledge from annual fire training. This was an area identified for improvement by the inspector. The drills recorded the time taken for staff to respond to the alarm. However, the drills did not include different scenarios or simulated evacuation practice. There was no evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

There was one resident who smoked residing in the centre at the time of this inspection. A risk assessment was completed. Cigarettes and lighters were held in safekeeping by staff. A care plan was in place to detail the level of supervision and assistance required by the resident.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Records sheets were available to record neurological observations where a resident sustained an unwitnessed fall or a head injury.

However, there was variation in how neurological observations were completed. There were not completed in all cases in line with the falls policy. This was an area identified for improvement on the previous visit. Individual strategies were outlined and utilised to minimise the risk of residents sustaining a fall to include, referral to the physiotherapist, closer observation and increased comfort care. While a post incident review was documented a standardised post falls assessment tool was not available for use.

There was a good cleaning system in place to break the cycle of infection and minimise the risk of cross contamination. Separate cleaning equipment and cloths were used to clean each bedroom and communal areas. There were a sufficient number of cleaning staff rostered each day of the week. Staff were able to explain how they cleaned a room in the event of an outbreak of infection in line with best practice.

Judgment:

Substantially Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

Medication reconciliation systems required development to identify any discrepancies to minimise the risk of medication error. Each resident's medication was delivered by the hospital pharmacy located on the adjacent grounds. Each resident's medication was dispensed from their individual named packages. However, the dispensed medication on arrival was not checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication. The prescription sheets reviewed were legible and distinguished between regular and short term medication.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medication was being crushed for one resident in the long stay unit prior to administration due to swallowing difficulty by the resident. Links were established with the pharmacist and where possible a liquid or dispersible form of the medication was obtained. There was consent for crushing signed by the GP for each drug individually on the prescription sheet. However, the max dose for all PRN (as required) medication was not in place for all drugs in the sample of prescriptions reviewed. This was an area identified for improvement in the previous report.

Medicines were being stored safely and securely in the clinic room which was secured. The temperature ranges of the medicine refrigerator was being appropriately monitored

and recorded.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

The inspector identified a recent medication error. This was documented in the risk register and appropriate action was taken to respond to the incident. However, a specific medication error reporting form is not available to guide staff on capturing all relevant details of such incidents with prompts to guide in appropriate responsive action.

There was a medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration. However, the procedures to respond to medication errors were not detailed well. This aspect of the policy required review to ensure clear guidance for staff.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed a record of incidents/accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

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

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

Findings:

The centre provides accommodation for a maximum of 36 residents. A maximum of 22 residents are accommodated for continuing care in one unit. Fourteen residents are accommodated in another for respite or convalescent care. At the time of inspection there were 20 residents in the long stay unit. Thirteen were maximum dependency and five were assessed with high care needs. There were nine residents with maximum care needs and three with high dependency levels in the short stay unit.

The inspector reviewed four resident's care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, a wound problem, potential behaviour that challenges and poor cognitive functioning, residents at high risk of falls and two with palliative care needs. There was an improved standard of care planning practice since the previous inspection.

Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments. There was a record of the resident's health condition and treatment given completed at a minimum twice daily.

Residents' assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. In the sample of care plans reviewed there was evidence care plans were updated at the required intervals or in a timely manner in response to a change in a resident's health condition. The risk assessments completed were suitably linked to care plans where a need was identified. Staff demonstrated good knowledge of the residents care needs and understanding of each resident's background in conversation with the inspector.

There was documentary evidence that residents or their representative were involved in the development and review of the resident's care plan when being reviewed or updated.

Care plans for residents with dementia or behaviours that challenge require more detailed development to ensure they are person-centred and individualised. Information such as who the resident still recognises or what activities could still be undertaken which guide staff practice was not evident.

Residents had access to GP (General Practitioner) services and there was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. A review of residents' medical notes showed that GP's visited the centre regularly. The GP's reviewed and re-issued each resident's prescriptions every three

months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals to include speech and language therapist, dietetic service and occupational therapy was available to residents on referral. Where residents had specialist care needs such as mental health problems there was evidence in care plans of good links with community mental health services.

There was one resident with a pressure wound on the day of inspection. The file reviewed evidenced recommendations from a clinical nurse specialist. This detailed the type and frequency of dressing. Clinical documentation reviewed evidenced management of the wound and healing was in progress.

Judgment:

Substantially Compliant

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):

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

Findings:

As identified on previous inspections, the physical environment does not comply with Regulation 17, Schedule 6 and the Authority's standards. Some remedial work and changes in practice have been undertaken to improve the quality of life for residents. A bath was provided for use by residents and a sufficient number of wash hand basins were fitted in each communal bedroom. Television screens were provided in each communal bedroom. An accordion style screen is provided around each bed to assist in maintaining privacy while personal care is in progress. However, as there are four beds in each communal bedroom, the use of the screens encroaches on other residents' personal space and privacy. While the screens are in use mobility within the bedrooms is restricted and access/egress from the communal bedrooms impeded.

There is one day sitting room and dining room in each of the units which is suitable in size to meet the numbers of residents. Other facilities include a hair salon, smoking room and a small visitor's room. Staff facilitates are provided in each unit with lockers to secure personal belongings.

The building was comfortably warm. Hand testing indicated the temperature of radiators and dispensing hot water did not pose a burn or scald risk to residents. However,

aspects of maintenance required attention. Plaster has come loose from the wall in one of the bathrooms and the cleaner's storeroom. Paintwork requires attention in some bathrooms as it is flaking from the wall and not easily cleanable in all part of the building. Woodwork to include skirting boards and wooden window frames were not well maintained.

The physical environment continues to pose challenges to meet residents' individual and collective needs and assure their comfort and privacy. Bedrooms were not en suite and there were limitations in the ability to maintain residents' privacy. Some bathroom facilities contained two toilets enclosed with a cubicle. Residents' privacy was not fully ensured as some cubicles were not partitioned all the way to the ceiling.

While there were a sufficient number of toilets and bathing facilities, residents wishing to have a bath had to enter triple bedroom to gain access to the bathroom. While a screen was fitted to partition a section of the bedroom it was not a realistic long term solution. One shower room in the short stay unit was not used as the physical size of the shower area could not accommodate a hoist. There were no grab rails fitted in the shower area to assist any mobile resident.

Each multi occupancy room was open onto a corridor linking all of the communal bedrooms allowing visitors to move unrestricted between rooms on the previous visit. The day sitting room and dining room were also open to the corridor and communal bedrooms immediately adjacent to the day environment could only be screened with curtains. Since the last inspection the fire doors along this corridor have been closed. Notices have been placed on the door requesting staff not to use the door as a means of access unless in the event of a fire evacuation. This has helped to achieve a quieter environment for residents and assist controlling the movement of people around the unit between communal bedrooms.

There were four single bedrooms in the long stay unit, one which is used for end of life care. However, these bedrooms were not structurally segregated. There are two entrances to these bedrooms. One via the door from the main corridor and the other on the opposite side of the bedroom from a corridor which runs along the front of the building. To provide screening between the single bedrooms a curtain is available which when closed obstructs most natural daylight. While the bedroom designated for end of life care was at the end of the corridor it was separated from the adjacent single bedroom by a partition which did not reach to ceiling height.

While each resident had their own wardrobe they were small in size limiting choice in the selection of clothing for storage. The corridors were clear of obstructions on the day of inspection. Specialist chairs, hoists and other equipment utilised by residents were stored at the end of a corridor between two single bedrooms. This area is not accessed by residents.

There was not an enclosed, safe outdoor space provided for residents use.

The provider at the time of this inspection did not have in place a plan to reconfigure multiple occupancy bedroom accommodation. This is required in accordance with the premises and physical environment regulatory notice and the National Quality Standards

for Residential Care settings for Older People in Ireland.

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 comprehensive complaints policy in place. This was revised since the last inspection as the complaints administrative procedures were not meeting the requirements of the regulations. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise. Formal complaint procedures and appeals details were outlined in the HSE complaints policy 'your service your say'.

The inspector reviewed the complaints procedure and noted this displayed inside the main entrance. A comments box was provided adjacently. A designated individual was nominated with overall responsibility to investigate complaints. A nominated person who would monitor that the complaints process was followed and recorded (independent of the person responsible to investigate the complaint) was identified.

There were robust internal mechanisms within the centre's policy to resolve complaints. The timeframes to respond to a complaint, investigate and respond to complainant were outlined. There was an independent appeals process if the complainant was not satisfied with the outcome of their complaint.

No complaints were being investigated at the time of inspection. A complaints log was in place which contained the facility to record all relevant information about complaints. There was evidence complaints were resolved to the satisfaction of the complainant.

Judgment:

Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

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

Findings:

This outcome was the subject of a thematic inspection in July 2014 and all aspects of end of life were examined in detail during the inspection. The areas identified for improvement from the last inspection were reviewed during the course of this visit.

Resident's end-of-life care preferences/wishes are identified and documented in their care plans. These plans included good detail of spiritual preferences. However, the end of life plans requires review. Residents were not all consulted regarding their future healthcare interventions, in particular transfer to hospital in the event that they became seriously ill and were unable to speak for themselves.

Records reviewed evidenced good input by the palliative team to monitor and ensure appropriate comfort measures for residents approaching end of life.

Judgment:

Substantially Compliant

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

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

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

Findings:

This outcome was the subject of a thematic inspection in July 2014 and all aspects of food and nutrition were examined in detail during the inspection.

Residents spoken to during the visit and relatives in questionnaires returned to the Authority expressed satisfaction with the food provided and the choices available to them. The inspector reviewed the menu and discussed options available to residents with the chef. There were nutritious snack options available between meals to ensure sufficient or optimum calorific intake particularly for those on fortified diets.

All residents were required to confirm their menu choices for all meals in the afternoon time a day in advance of having their meals on the previous inspection. Catering and care staff indicated all meal options are confirmed on the day and again at each meal

time.

Residents' food likes and dislikes were recorded and served meals in accordance with their preferences and dietary restrictions. The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff.

There was prompt access to the GP and allied health professionals for residents who were identified as being at risk of poor nutrition or hydration. There was ongoing monitoring of residents nutritional and hydration needs. Staff monitored the food and fluid intake of residents identified with a nutritional risk. Food intake records were well completed consistently and included the amount of prescribed supplements consumed. Fluid charts were totalled. However, there was not a system in place to review fluid records and ensure each resident's daily fluid goal was achieved and allow for intervention at the earliest stage possible if issues arose.

All residents were weighed regularly. At the time of this inspection three residents required close monitoring and were being weighed every two weeks. There was evidence of referral to allied services and reviews by the dietician and the speech and language therapist. Care plans were revised to reflect updates following reviews by allied health specialists.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents' civil and religious rights were respected. Residents and staff confirmed that they had been offered the opportunity to vote at each election either in house or their own locality. Residents could practice their religious beliefs. There was a visitor's room to allow residents meet with visitors in private.

Residents had access to a variety of national and local newspapers and magazines to reflect their cultural interests and heritage. These were located in easily accessible areas and available to residents daily. A residents' forum was in place.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by the activities coordinator, employed five days each week. The inspector spoke with the activity coordinator who confirmed the range of activities in the weekly program. The activity schedule provided for both cognitive and physical stimulation.

Judgment:

Compliant

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.***

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed a policy for the managing of residents' personal property. It provided guidance to staff on the storage and care of residents' belongings. The centre provided the service to laundry all residents' clothes and families had the choice to take home clothes to launder if they wished.

The inspector checked items of clothing in resident's wardrobes and noted names were recorded on all clothing.

A property list was completed with an inventory of all residents' possessions on admission. This was updated routinely.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The provider employs a whole-time equivalent of 16 registered nurses and 20 care/catering attendants. In addition, there is cleaning, maintenance and an activity coordinator employed. The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty.

The inspector judged there was an adequate complement of staff with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre. However, it was evidenced from reviewing the staff rosters there was no clinical nurse manager rostered for duty any weekend on a regular basis. This deficit poses a risk to good clinical governance, adherence to policies informing practice and an inadequacy to ensure staff supervision.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. In addition to mandatory training required by the regulations staff had attended training on cardio pulmonary resuscitation techniques. However as identified under Outcome 8, Health and Safety and Risk Management, all staff did not have refresher training in moving and handling. Further training on end of life care and nutrition was required to ensure all staff are trained. This was an area identified for improvement in the action plan of the previous inspection report. There was an ongoing program of staff training in behaviour management.

A record of An Bord Altranais PINs (professional identification numbers) for all registered nurses was maintained.

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:

PJ Wynne
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:	Lisdarn Centre for the Older Person
Centre ID:	OSV-0000490
Date of inspection:	13/04/2015
Date of response:	22/05/2015

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

A pro active auditing program was not established with key areas identified for review during 2015; with the aim to identify trends in the data collated with the objective of developing improvement plans to ensure enhanced individual outcomes for residents.

Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The Registered Provider will ensure that there will be in place a pro-active auditing program identifying key issues for example restraint, medication and end of life care planning, with the aim of identifying trends in the information collected , the objective been to enhance individual outcomes for each resident.

The Registered Provider will put in place a management system to ensure that the service provided is, safe, appropriate, consistent and effective. This will involve management undertaking spot checks at various times throughout the week to include weekends and night duty.

Proposed Timescale: 31/07/2015

Theme:

Governance, Leadership and Management

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

An annual report on the quality and safety of care was not compiled for 2014 with copies made available to the residents or their representative for their information as required by the Regulations.

Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

The Registered provider will undertake an annual review of the quality and safety of care and this will be forwarded to the authority and made available to the residents or their representative for their information as required by the regulations.

Proposed Timescale: 31/07/2015

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:

The details of the cause of death when established were not recorded in the directory of residents'.

Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

The Registered Provider will put in place a system to ensure that the cause of death will be included on the directory of residents.

Proposed Timescale: 15/05/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Further work is required in exploring alternative options prior to using a restraint measures to promote a restraint free environment in line with the national policy.

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 registered provider will put in place a system whereby all alternative options will be explored and clearly documented prior to the use of any form of restraint. This will be done by:

- Continuing to promote a restraint free environment.
- Continuing the ongoing trial of alternative measures e.g crash mats, sensor alarms, low, low beds.
- Assessment for the use of a bedrail will continue to be used prior to the use of bedrails. Residents will continue to be advised of the risk of bedrail usage prior to their introduction.

Proposed Timescale: 01/06/2015

Theme:

Safe care and support

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

Training in protection of vulnerable adults for a further eight staff was required.

Action Required:

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

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

The Registered Provider will ensure that training is provided in the Protection of Vulnerable Adults.

Training in the detection and prevention of and responses to abuse has been arranged for the 22nd May and the 26th May 2015

Proposed Timescale: 26/05/2015

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:

There was variation in how neurological observations were completed. There were not completed in all cases in line with the falls policy.

While a post incident review was documented a standardised post falls assessment tool was not available for use.

Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

The Registered Provider will ensure that there is no variation in how neurological observations are completed.

- The neurological recording chart will be revised to indicate the time intervals for recording observations and staff will be educated in this area.
- A standardised post fall assessment tool will be devised and staff will be made aware of this tool prior to introducing it.

Proposed Timescale: 01/06/2015

Theme:

Safe care and support

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

Fire drills did not include different scenarios or simulated evacuation practice. There was no evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

The Registered Provider will ensure that fire drills include different scenarios or simulated evacuation practice.

- A simulated evacuation has been carried out 21/5/15 and an evaluation of learning has been completed and recorded.
- Similar fire drills will be carried out throughout the year.

Proposed Timescale: 21/05/2015

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:

Dispensed medication on arrival was not checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident. Medication reconciliation systems were not well developed to identify any discrepancies

Action Required:

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

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

The Person in Charge will ensure that dispensed medication will be checked against the prescription sheets. This will be done by:

- On receipt of medication stock will be checked against the prescription.
- There will be a folder maintained that will include a copy of checked prescription and this will be signed and dated by the receiving nurse.
- On admission to the short stay unit the drugs taken in the resident will also be checked against the prescription and recorded and signed for by the receiving nurse on the drug administration kardex.
- Discrepancies identified will be recorded on the prescription sheet and the dispensing pharmacist informed.

Proposed Timescale: 08/06/2015

Theme:

Safe care and support

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

The max dose for all PRN (as required) medication was not in place for all drugs in the sample of prescriptions reviewed.

Action Required:

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

regarding the appropriate use of the product.

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

The Person in Charge will ensure that all PRN medications have been updated to include the maximum dosage is include on the prescription.

Proposed Timescale: 14/05/2015

Theme:

Safe care and support

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

The procedures to respond to medication errors were not detailed well. This aspect of the policy required review to ensure clear guidance for staff.

Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The Registered Provider will ensure that the medication policy will be updated in response to medication errors. This will include clear guidance on the procedure to be followed in the event of a medication error occurring.

Proposed Timescale: 08/06/2015

Theme:

Safe care and support

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

A specific medication error reporting form is not available to guide staff on capturing all relevant details of such incidents with prompts to guide in appropriate responsive action in the event of a medication error.

Action Required:

Under Regulation 04 (3) you are required to: Review the policies and procedures at intervals not exceeding 3 years, or as often as the chief inspector may require and, where necessary, review and update them in accordance with best practice.

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

The Registered Provider has put in place a specific form for reporting Medication errors. Form attached. This form includes prompts to guide staff in the appropriate responsive actions that need to be taken in the event of a medication error.

Proposed Timescale: 08/06/2015

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:

Care plans for residents with dementia or behaviours that challenge require more detailed development to ensure they are person-centred and individualised. Information such as who the resident still recognises or what activities could still be undertaken which guide staff practice was not evident.

Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

The Registered Provider will ensure that care plans for those residents who have dementia or are cognitively impaired will be more person-centred. This will be done by:

- Care plans of residents with dementia or behaviours that challenge will be further developed and completed in collaboration with the residents next of kin, a questionnaire will be devised to include who the resident now recognises and what activities they can now participate in. This will enable staff to be better informed about the resident and how best to deal with particular challenges from individual residents.

Proposed Timescale: 05/07/2015

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:

The physical environment does not comply with Regulation 17, Schedule 6 and the Authority's standards.

- There are four beds in each communal bedroom the use of the screens encroaches on other residents' personal space and privacy. While the screens are in use mobility within the bedrooms is restricted and access/egress from the communal bedrooms impeded.
- Bedrooms were not en suite and there were limitations in the ability to maintain residents' privacy. Some bathroom facilities contained two toilets enclosed with a cubicle. Residents' privacy was not fully ensured as some cubicles were not partitioned all the way to the ceiling.
- Residents wishing to have a bath had to enter triple bedroom to gain access to the bathroom. While a screen was fitted to partition a section of the bedroom it was not a realistic long term solution. One shower room in the short stay unit was not used as the physical size of the shower area could not accommodate a hoist. There were no grab

rails fitted in the shower area to assist any mobile resident.

-Single bedrooms were not structurally segregated. There are two entrances to these bedrooms. One via the door from the main corridor and the other on the opposite side of the bedroom from a corridor which runs along the front of the building. To provide screening between the single bedrooms a curtain is available which when closed obstructs most natural daylight. While the bedroom designated for end of life care was at the end of the corridor it was separated from the adjacent single bedroom by a partition which did not reach to ceiling height.

-Aspects of maintenance required attention. Plaster has come loose from the wall in one of the bathrooms and the cleaner's storeroom. Paintwork requires attention in some bathrooms as it is flaking from the wall and not easily cleanable in all part of the building. Woodwork to include skirting boards and wooden window frames were not well maintained.

-There was not an enclosed, safe outdoor space provided for residents use.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

The Registered Provider is acutely aware of the infrastructural challenges within this unit. The Registered Provider and Person in Charge continues to work with all staff to ensure that every effort is made to maximise privacy and dignity for all residents taking into consideration the infrastructural challenges.

Immediate Plan to maximise privacy and dignity for current residents.

- All internal doors on corridor to the front of the building are now closed. This has enabled the manager to ensure that each cubicle is private for the 4 residents who live there. The magnets on these doors have been removed, the fire officer has assessed this and in the event of a fire emergency egress from this cubicle is still possible.
- The corridor to the rear of the building is now used by staff for general care, catering and cleaning duties.
- Work has been completed on the cubicle beside where the bathroom is situated to allow privacy for residents to use the bathroom-this involves the use of screens and the realignment of beds in this cubicle.
- Rooms in this area have been realigned and this has resulted in 2 single rooms. One of these rooms is now used as an end of life room.
- Privacy sheets will be placed on the windows to the front of the building to maximise privacy for residents.-July 2015
- General Repairs will take place on
- Guttering,
- Replacement of windows
- Redecorating of communal areas.
- Repair of plaster on a number of walls.

Funding has been approved for the above and a meeting with colleagues from estates was held on site Wednesday 20th May to action the above. Following on from this meeting estates colleagues have agreed to refurbish 2 Shower Areas within the centre

and to construct a 'lobby' area leading into the assisted bathroom. This work will commence July 2015.

The Registered Provider seeks registration from the Health Information and Quality Authority for the Lisdarn Unit as a long term care facility from June 2015 to June 2018. During this period capital works will be ongoing in the Virginia Residential Unit, Breffnie Care Centre and the Sullivan Centre. Until these works are complete the HSE will require the use of the long term care beds currently in the Lisdarn Unit.

During this period the Person in Charge and the Nominee of the Registered Provider will work in consultation with colleagues in the acute hospital and colleagues in the community to reconfigure the beds for use as step down beds for use by the acute hospital and for use by the community.

Proposed Timescale: 30/06/2018

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

All residents were not all consulted regarding their future healthcare interventions, in particular transfer to hospital in the event that they became seriously ill and were unable to speak for themselves.

Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The Person in Charge will ensure that an End of Life care plan is drawn up in consultation with each resident and family member. This will now include the residents wishes regarding transfer to hospital in the event that they become seriously ill.

An end of life questionnaire has been devised. This will be given to residents and NOK to complete in order to identify residents wishes regarding end of life care. A record of this will be maintained in the residents file.

Proposed Timescale: 08/06/2015

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:

There was not a system in place to review fluid records and ensure each residents daily

fluid goal was achieved and allow for intervention at the earliest stage possible if issues arose.

Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

The Person in Charge will ensure that there is a system in place to review fluid records and ensure each resident's daily fluid goal is achieved. This will be done by:

Staff will document the fluid intake and output on the evaluation kardex and this will ensure that during handover reports this area is highlighted. This will ensure that each resident's daily fluid goal is being reached or in the event of it not it will allow for early intervention to avoid dehydration of the resident.

Proposed Timescale: 01/06/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

All staff did not have refresher training in moving and handling.

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:

The Person in Charge will ensure that all staff receive refresher training in moving and handling. Remaining staff who had not received a refresher in manual handling will be attending this training 20/5/15

Proposed Timescale: 20/05/2015

Theme:

Workforce

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

Further training on end of life care and nutrition was required to ensure all staff are trained.

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:

The Person in Charge will ensure that there is further training on end of life care and nutrition.

Training on nutrition is planned for 19/5/2015 and 26/5/2015.

Further End of Life training is currently been sourced to enhance staff training in this area.

Proposed Timescale: 30/09/2015

Theme:

Workforce

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

There was no clinical nurse manager rostered for duty any weekend on a regular basis. This deficit poses a risk to good clinical governance, adherence to policies informing practice and an inadequacy to ensure staff supervision.

Action Required:

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

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

The Person In Charge will ensure that all management within the unit will have their rosters reviewed. During this review weekend and evening 'spot checks' will be included and records of these visits kept in the unit.

Proposed Timescale: 01/06/2015