Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Raheny Community Nursing Unit
Centre ID:	OSV-0000704
Centre address:	Harmonstown Road, Raheny, Dublin 5.
Telephone number:	01 850 5600
Email address:	rcnu@beaumont.ie
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Beaumont Hospital
Provider Nominee:	Mary Keogh
Lead inspector:	Leone Ewings
Support inspector(s):	Jim Kee;
Type of inspection	Unannounced
Number of residents on the date of inspection:	99
Number of vacancies on the date of inspection:	0

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
22 April 2015 09:00	22 April 2015 19:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This was an unannounced inspection of the centre. The inspection took place over one day and was for the purpose of monitoring compliance. Additionally the purpose of the inspection was to focus on reviewing complaints procedures, further to unsolicited information received by the Authority over recent months from relatives who were dissatisfied with the management of their complaints. The provider and person in charge were present for the duration of the inspection and provided documents as requested by inspectors. The Authority had been notified of changes to key senior managers at the service and two of the managers on duty completed satisfactory interviews with the inspector, and confirmed information submitted to the Authority.

The designated centre provides long term care for older persons and one resident was in hospital at the time of the inspection. Inspectors found evidence of good

practice in all 13 Outcomes inspected at the time of the inspection. The inspectors found that overall the provider met some of the requirements of 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. However, improvements were required and the standard of audit and review of service provision was not adequate. This report sets out the findings of the inspection and areas identified for improvements.

The inspectors found that the health needs of residents were met to a good standard. Residents had access to medical care, to a full range of other allied health services and the nursing care provided was of a good standard. However, areas for improvement were identified and the centre was non-compliant in 8 of the 13 outcomes inspected against; improvements requirement include a major non-compliance relating to governance and management. Moderate non-compliances in documentation, complaints procedures, safeguarding and safety, health and safety and risk management, medication management and notifications. One outcome, staffing was substantially compliant. The remaining five outcomes were compliant.

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 inspector reviewed the most up date statement of purpose submitted on 1 April 2015 and found that it accurately described the services and facilities provided in the centre and that the information was in accordance with regulatory requirements and reflects the most recent registration certificate.

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

Findings:
Inspectors found that one action from the previous inspection relating to medication management practices in the centre had not been satisfactorily implemented, and that the provider had not put in place robust systems to review quality and safety of care

and annual review of quality and safety of care delivered to residents had been completed to date.The person in charge had commenced using a nursing metrix system further to the last registration inspection, but his information had not fully informed a report as required by legislation.

The inspectors found that there were sufficient resources to ensure the delivery of care in accordance with the statement of purpose. Outstanding documentation requested on inspection and information submitted post inspection on 29 April 2015 was not sufficiently detailed enough. The management systems in place were found not to be fully effective and did not always ensure good outcomes for residents, or effectively address non-compliances identified on previous monitoring events.

There was a defined management structure that identifies the lines of authority and accountability. The person in charge, was found to work closely with the provider nominee and her deputy nurse manager to undertake the responsibilities of person in charge. Relatives and residents confirmed that they could identify with the management team; the person in charge was visible at the centre on a daily basis. A clinical nurse manager 3 has been appointed following a change of the previous post-holder notified to the Authority. However, the inspectors were not satisfied that robust systems were in place to sufficiently audit and closely monitor and review aspects of service provision; staffing, health and safety, training, policies and complaints. Some improvements were required in management systems to ensure that the service provided continues to be safe, appropriate to residents' needs, consistent and effectively monitored, particularly around medication management, record keeping and complaints management. Evidence of audit and review of practice following audit was not fully evidenced by the person in charge. For example, falls and incident management and the necessary follow up to ensure resident safety and prevent further incidents.

There were systems in place to review and monitor the quality and safety of care and the quality of life of residents on a three monthly basis. There was some evidence of consultation with residents and their representatives and actively working on any feedback received from residents and relatives. However, an annual report on quality and safety in line with legislative requirements was not available at the time of the inspection. As outlined in Outcome 13 the inspectors were not satisfied that the learning from complaints received from residents and relatives were sufficiently communicated or documented in line with best practice.

Judgment:
Non Compliant - Major

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

Findings:
Residents had access to a written guide to the centre. The resident guide included all the information specified in Regulation 20, of the Health Act 2007, (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Inspectors reviewed a sample of contracts, including the contract of the most recent admission to the centre. The contracts included details of the services to be provided for residents and outlined the residents' weekly charges, as well as reference to the fees charged for prescriptions.

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 had not changed since the time of the last inspection and registration process. She worked full time at the centre as an assistant director of nursing, and had the required skills, knowledge and experience. She had day to day responsibility for all services at the centre, and line managed all staff both those providing direct and in-direct care.

The person in charge was available and fully facilitated the inspection process on the day of the inspection. She informed inspectors that her working hours had changed recently but this was not reflected on the rosters viewed. She demonstrated an approach to her work which was consistent with a high standard of person centred care. As outlined in Outcome 5, improvements were required with documentation and her daily working hours were not found to be fully maintained on the rosters shown to inspectors, as required by the legislation.

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

Findings:
The inspector found that the provider had not addressed the non-compliance further to the registration inspection; policies had not been reviewed or updated as required further to changes and service development in areas such as complaints, medication management and safeguarding. Overall the records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 required improvement particularly relating to the residents nursing care records, records of staff training, policies review and complaints records.

Nursing and clinical records were maintained and any records reviewed were found to be person centred. Clinical nurse managers described how records were reviewed on a weekly basis to ensure completeness. However, there was no systematic review or audit tool used and gaps in documentation were found with examples shown to staff and described at feedback to the person in charge. Overall nursing and care records were found to be completed to a fair standard, but improvements were required with regard to meeting each residents assessed and changing needs.

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 Centre for Older People) Regulations 2013.
Inspectors found that the centre's policy on elder abuse, that detailed the procedures for the prevention, detection and response to abuse as detailed in Schedule 5, had not been reviewed in the last three years. The policy on the management of complaints was dated 2013 and required review to ensure that the new information leaflet published "to assist you in making a compliment, comment or complaints" recently updated by the provider. A policy in place for the management of patients requiring 1:1 constant observation was in draft format and was dated 2007 and was not service specific, or did not fully inform staff if residents were identified as requiring additional supervision.

Inspectors also found deficiencies in the documentation of medication administration as detailed in Schedule 3 of the Regulations. Inspectors observed the administration of

medicines to residents during medication rounds on various units within the centre and found that some nursing staff were signing the administration record before administering the medicines to the residents, which is not in line with best practice, or professional guidelines. Inspectors also found that the allergies section of some prescription sheets had not been completed to indicate residents' known drug allergies or if there were no known drug allergies. The medication management policy made available to inspectors during the inspection had no date of implementation or any date of review indicated on the policy. This policy did not include any guidance on the ordering or prescribing of medicines, or on the handling and disposal of unused or out of date medicines as detailed in Schedule 5 of the Regulations.

Judgment:
Non Compliant - Moderate

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:
At the time of the inspection the person in charge had not been absent for more than 28 days which required notification to the Authority. The inspector formed the view that there were suitable arrangements in place for the management of the centre in the absence of the person in charge. The clinical nurse manager 3 had changed since the time of the last inspection, and a newly appointed person had commenced in the role during December 2014. She took charge of the centre when the person in charge was absent or on leave, and she was supported by four clinical nurse managers. She completed a satisfactory interview to ascertain fitness to undertake this role and was found to be closely involved in the day to day supervision of practices at the centre.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Inspectors were not satisfied that appropriate measures were in place with regard to the safeguarding of residents, or to ensure that alternatives to the use of restrictive practices, such as the use of bedrails were considered.

There was a policy on elder abuse available within the centre. However this policy had not been reviewed in the last 3 years as detailed in Outcome 5. Staff with whom inspectors spoke were knowledgeable with regard to their responsibilities in this area, but some members of staff had no recent training in safeguarding and the prevention of elder abuse.

Residents with whom inspectors spoke stated that they had no concerns regarding their safety in this centre. Security staff were available on the main reception desk during the day, where a visitors log was maintained.

There was a policy and procedures in place for the management of challenging behaviour, and staff spoken to during the inspection confirmed that they had received training on managing these behaviours. Behaviour observation charts were being completed for some residents at the time of the inspection.

The use of restraint was recorded in a restraints register on each unit, and daily nursing assessments of restraint were conducted. However, the inspectors found that the use of restraint, was not fully in line with best practice and national policy. For example, alternatives implemented prior to use of any restrictive measure was not outlined in the risk assessments completed. Training had not been provided to staff on best practice in the use of any restraint. There was no evidence of alternatives available other than the use of low low beds.

There were systems in place to safeguard residents' finances, including a policy on management of residents' accounts and valuables. The provider was acting as a pension agent for two of the residents, and inspectors were satisfied having reviewed the procedures and documentation that the current system was sufficiently transparent and secure. Staff within the centre maintained individual comfort funds to enable residents to avail of the hairdresser and other services, and detailed records and receipts were available for these funds.

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:
All lines of enquiry were not reviewed by inspectors in this Outcome. The inspectors confirmed that the matters relating to emergency lighting and risk assessments of residents' door and balconies had been implemented by the provider.

The inspectors found that the health and safety of residents, visitors and staff was promoted and protected. However, improvements were required relating to the arrangements for investigation and learning from serious incidents or adverse events involving residents.

The inspector noted that the safety statement shown to inspectors was dated 2011, and the person in charge informed inspectors that the draft safety statement was currently under review. The risk register reviewed was kept up to date and internally the building was found to be kept relatively hazard free. Environmental risk was addressed with health and safety policies implemented which included risk assessments on such areas as environmental hazards. A risk management policy was in place and met the requirements of the Regulations.

Fire precautions were prominently displayed throughout the centre. Service records showed that the emergency lighting, fire alarm system and fire fighting equipment were serviced and fully maintained. The inspector noted that the fire alarm was last checked on 21 April 2015, and was due for a service, which was scheduled for April 2015. The means of escape and exits, were clear and unobstructed. Staff had attended training and those spoken with were knowledgeable of the procedure to follow in the event of a fire. An emergency evacuation plan was in place which provided clear guidance to staff, which identified what to do in the event of fire, flood, loss of power or heat or any other possible emergency. The emergency plan outlined the specific support requirements for residents in case of emergency.

Complete mandatory training records requested on inspection were not available, and a request made to submit to the Authority. The details submitted on 29 April 2015 were not sufficient to make a judgement on whether the provider had evidnenced completed mandatory training. Staff interviewed on inspection had completed moving and handling, fire and safeguarding. However, staff rosters discussed with clinical nurse managers confirmed that a small number of staff were waiting to attend refresher fire and safeguarding training. Staff confirmed that they had up to date knowledge on the use of moving and handling equipment. There was sufficient equipment provided for the safe moving and handling of residents such as fixed and portable hoists and other moving and handling aids to mobility.

Falls and incidents reported were reviewed by the peson in charge, where the incident reports were signed, and on each occasion satisfactory measures were in place to mitigate the risks associated with recorded individual incidents. However, the current review process in place was not sufficiently robust to evaluate that many of the accidents and incidents which took place at the designated centre. The inspectors were satisfied that medical review took place where required. However, the review of the residents care plans and the review of falls risk did not take place in all cases.

For example, two incidents of challenging behaviour which took place were not sufficiently reviewed from with regard to documentation of risks associated with identified triggers and review of behaviours of concern by the person in charge. The person in charge was requested to review this process in line with clinical documentation review.

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

Findings:
Inspectors found that one action from the previous inspection relating to medication management practices in the centre had not been satisfactorily implemented, and that medicines were still being left unsecured on the drugs trolley during medication rounds . Inspectors observed a number of practices that were not consistent with appropriate medication management practice, including the documentation of administration of medicines to residents, storage conditions for certain medicines, lack of segregation of expired medicines and medicines no longer required by residents, and prescribing issues. The medication management policy made available to inspectors was found to be unsatisfactory in providing guidance to staff in certain aspects of medication management. Some of these findings and actions required are detailed under Outcome 5.

Medicines were supplied by a retail pharmacy business, and were appropriate, dispensed in a monitored dosage system that consisted of individual 'pouches'. Staff informed inspectors that the pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland. Inspectors also reviewed a recent medication audit conducted by the pharmacist to monitor medication management practices within the centre.

Inspectors found that one particular eye drop that required storage in a refrigerator was being stored incorrectly at room temperature. Inspectors also found an expired medicine, and medicines that were no longer required by residents including blister packed medicines, that had not been appropriately segregated and returned to the pharmacy for disposal. These medicines were found to be stored with other medicines in one of the storage cupboards on one of the units, indicating poor medicine storage and disposal practices. Inspectors observed medication administration in a number of the units, and on one of the units inspectors found that residents' individual medicine 'pouches' were being left unattended and unsecured on top of the drugs trolley during the medication round.

Inspectors reviewed a number of medication prescription and administration sheets and identified that the prescriber had not indicated that crushing was authorised for each individual prescribed medicine.

All controlled (MDA) medicines were stored in secure cabinets within each unit, and a register of these medicines was maintained with the stock balances checked and signed for by two nurses each day. Fridges were available to store all medicines or prescribed nutritional supplements that required refrigeration, and fridge temperatures were monitored on a daily basis.

Medication usage reviews were conducted within the centre on a regular basis, and medication errors were appropriately recorded on incident report forms, and reported to the pharmacy vigilance officer in Beaumont Hospital. There were plans to conduct internal audits of medication management, including review of prescription sheets, medicine administration records and the administration of medicines, but none of these had been carried out before the inspection.

At the time of inspection there were no residents receiving intravenous (IV) antibiotic therapy. A policy was in place for the administration of IV drugs/therapy within the centre, and nursing staff informed inspectors that training had been provided on the administration of IV medicines.

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 person in charge had not submitted all statutory notifications in line with requirements of the regulations. The inspectors were not satisfied that adequate systems were established to fully implement this requirement of the legislation. Examples of this include a cause of death was not submitted to the Authority (when known) further to a notification about an unexpected death at the centre. Quarterly notifications were found to be submitted late and outside the required time frame for quarter four of 2014.

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 were satisfied that overall resident's healthcare and social care needs were met to a high standard and the arrangements to meet residents needs were set out in a care plan with the involvement of the resident or relatives. Residents had access to medical care, an out of hours services and a full range of other services available on referral including occupational therapy, speech and language therapy (SALT), dietetic services. Chiropody, dental and optical services were also facilitated. The inspectors reviewed residents' records and found that residents had been referred to services and records and results of appointments were written up in the residents' notes in a timely manner. The allied health professionals documented the assessments and reviews completed to inform the relevant nursing care plans.

Nursing assessments; care plans and additional clinical risk assessments were carried out for each resident. Daily notes were being recorded in line with professional guidelines, and in a person centred manner. Overall care plans reviewed by the inspector contained the required information to guide the care for residents, and were updated to reflect the residents changing care needs. However, the inspectors read the care plans of some residents who had fallen and saw that risk assessments were not reviewed and a care plan devised or updated to reflect the incident and fully mitigate risks identified. Preventative measures undertaken included the use of hip protectors and additional supervision of staff. A small number of residents had wander alarm

bracelets in place and alarms in place on their chairs to alert staff if they were getting up. There was good supervision of residents in communal areas and adequate staffing levels on the day of the inspection to ensure resident safety was maintained. There was an adequate policy in place on falls prevention to guide staff. Neurological observations were completed when residents sustained an unwitnessed fall. Records of clinical incidents which were found to be fully completed in a factual manner. Further follow up and audit has been identified in Outcome 8 as an area for improvement.

The inspector reviewed the records of residents notified as having a pressure ulcer, and residents risk assessed as being at risk of pressure ulcer or skin breakdown and noted that there were adequate records of assessment and appropriate care plans in place to monitor care. An evidence-based policy was in place which was used to guide the practice of nursing and care staff. Staff spoken to were knowledgeable of the strategies to be taken to prevent pressure ulcers, and appropriate pressure reducing strategies and care was in place for residents assessed as at risk, records of re-positioning and pressure relieving devices were found to be accurate and evidence based.

Judgment:
Compliant

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

Findings:
There was a written complaint's procedure clearly on display, and a leaflet to inform and guide residents and relatives. The Authority had received unsolicited information from relatives involved with the process, and expressing their dissatisfaction with the process and outcomes of their complaints.The person in charge was the complaint's officer and dealt with all complaints. In practice issues were recorded at local level and reviewed by the clinical nurse manager and were discussed and escalated to the person in charge where required. An independent appeals process was clearly outlined in the complaint's policy. The provider nominee oversaw the complaints process, which were discussed at management meetings, and she could evidence that she had been fully engaged with the oversight of a number of unresolved complaints.

Inspectors found that actions required from the previous inspection had been partially addressed and implemented, as the records of complaints reviewed at this time did not clearly inform the complainant of their right to an independent appeals process in all

cases. The systems to manage complaints had improved since July 2013, but the standard of documentation was not satisfactory or consistent to reflect investigation and fact finding process.The complaints management policy was reviewed by inspectors and dated 2013 and as outlined in Outcome 5 requires full implementation by the provider. Residents, relatives and staff who met with inspectors were aware of the complaint's policy and procedure, and confirmed their own understanding of the process. A monthly group residents meeting held with independent advocacy service took place and minutes were reviewed by the inspectors.

The inspectors confirmed that person in charge and staff had attended training in complaints management since the time of the last inspection. However, the records reviewed of the investigation and correspondence relating to serious and written complaints was not comprehensive or fully in line with the centre complaints process.

Further to a meeting with the provider nominee and the person in charge, the inspectors were not satisfied that the complaints policy was fully implemented at the time of this inspection, particularly relating to communication of findings and maintenance of complaints records.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
All lines of enquiry relating to staffing and recruitment were not fully reviewed on this inspection. On the day of inspection the inspectors found that the staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents. Overall, the residents, relatives and staff agreed that there were adequate levels of staff on duty and residents needs were met in a timely manner. The inspectors observed that nursing and healthcare assistants were involved with direct care of residents, and supported by catering, activity, household, portering, administrative and medical staff. Resident dependency was assessed using a recognised validated dependency scale and the

staffing rotas were adjusted accordingly. The inspector found that the nature of resident dependency had not increased substantially since the time of the last inspection.

Access to allied healthcare professionals was facilitated and evidence of assessment and review by dietetic, occupational therapy, physiotherapy, and speech and language was clearly demonstrated in the clinical documentation. Staffing levels were kept under review by the person in charge and her deputy on a daily basis and planning for the staffing roster. Residents and relatives confirmed to the inspector the availability of staff throughout the day and night and were happy with the standard of care at the centre. Staffing levels on Fuschia had increased since the time of the last inspection as a number of residents with dementia were accommodated and were mobile and had been identified as requiring additional supervision. The inspector found that there were satisfactory procedures in place for increased supervision of some identified residents. Residents with additional requirements for supervision had been identified and staffing was sourced, or via agency provision to supplement this identified need. However, the policy (as outlined in Outcome 5) to document and review increased supervision requirements was not service specific and did not fully inform staff involved with the assessment, planning and implementation of this requirement in a meaningful way.

A clinical nurse manager was individually responsible for supervising care for each of the four units. The clinical nurse manager was supported by their line manager and the person in charge. In practice the clinical nurse manager, staff nurses and health care assistants provided direct care and each unit had a daily handover outlining the residents health and social care status and their changing needs. A clinical nurse manager discussed the process of auditing the clinical documentation using their clinical judgment, and took place weekly. No training or formal audit process or tool had been put in place to facilitate the process of maintaining standards of clinical nursing documentation. Staff told the inspector they had received a broad range of training which included end of life care, infection control, dysphagia, bowel management. The person in charge informed inspectors that training had been sourced relating to management of challenging behaviours as this had been identified as a learning need. Training relating to audit and maintaining standards of clinical documentation in line with professional standards had not been sourced as a result of learning from a recent complaint investigation.

Staff appraisal systems had not yet been implemented by the person in charge in line with best practice.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Leone Ewings
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[1]

Centre name:	Raheny Community Nursing Unit
Centre ID:	OSV-0000704
Date of inspection:	22/04/2015
Date of response:	05/06/2015

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:
The provider has not completed an annual review of quality and safety of care delivered to residents in the designated centre.

1. 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

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

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:
Under regulation 23(d) the PIC will put in place an annual review programme to monitor the quality, safe care and quality of life of the Residents in the Centre.

The annual review will include the following audits:-

1. A suite of metrics have been put in place and are audited every two months. Findings are actioned and learning's are communicated to all staff by Clinical Nurse Managers.

1. Pressure Area Management 2. Falls
3. Medication Management 4. Hygiene
5. Nursing Care Plans 6. Invasive Devices
7. Restraint Assessment / Monitoring 8. Environment
9. Call Bells 10. Drinks

2. A quality of life audit will be conducted by means of a questionnaire to the residents and families. All outcomes will be discussed with the residents, staff and actioned appropriately.

3. The incident forms will be audited and discussed at our weekly management meetings with the CNM's, PIC and Provider. Findings and trends will be actioned and learning's communicated to all staff by Clinical Nurse Managers.

4. A safety walk around is conducted on a weekly basis and findings from same are discussed at our weekly management meetings and appropriate actions taken and learning's communicated to all staff by Clinical Nurse Manager.

5. All Complaints received are reviewed at our weekly management meetings to ensure they are followed up as per the current complaints policy.

6. The Eden alternative quality of life programme will be audited annually. Findings and suggestions will be discussed with residents, staff and implemented where appropriate.

7. Internal & external unannounced hygiene audits are carried out. Findings are actioned appropriately.

8. Catering meetings are held every six weeks with the Multi Disciplinary Team. All suggestion are discussed and where appropriate implemented to enhance the services.

The annual review of all the above audits will be carried out.

Findings, outcomes and actions will be discussed with residents, staff, provider and senior executive team (in Beaumont Hospital).

Proposed Timescale: 31/12/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems are not consistently in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Please state the actions you have taken or are planning to take:
1. A suite of metrics have been put in place and are monitored every two months.

1. Pressure Area Management 2. Falls
3. Medication Management 4. Hygiene
5. Nursing Care Plans 6. Invasive Devices
7. Restraint Assessment / Monitoring 8. Environment
9. Call Bells 10. Drinks

Action plans: - Findings will be displayed and discussed with the Clinical Nurse Mangers and action plans where necessary will be put in place and reviewed monthly. CNM's will ensure the metrics results and actions plans are discussed with all staff on an ongoing basis.

2. Communication systems have been revised with emphasis on handover at shift change:

· The resident "Daily Record Sheet" has been amended to ensure adequate record of resident wellbeing is documented and handed over at report time.

· The introduction of "Unit to Unit" transfer documentation has been developed and implemented. This test of change will be monitored and the learning will be used to sustain improvement.

3. Additional training is underway for all staff on documentation and information recording.

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:
Prepare the review of quality and safety in consultation with residents and their families.

3. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
1. A quality of life audit will be conducted by means of a questionnaire to the residents and families. All suggestions will be discussed with the residents, staff and actioned appropriately.

2. A dementia specific quality of life audit questionnaire will be made available to residents and families. All suggestions will be discussed with the residents, staff and actioned appropriately.

3. A safety walk around is conducted on a weekly basis and findings from same are discussed at our weekly management meetings and appropriate actions taken and learning's communicated to all staff by Clinical Nurse Manager.

9. All Complaints received are reviewed at our weekly management meetings to ensure they are followed up as per the current complaints policy.

4. The Eden alternative quality of life programme will be audited annually. Findings and suggestions will be discussed with residents, staff and implemented where appropriate.

5. Catering meetings are held every six weeks with the Multi Disciplinary Team. All suggestion are discussed and where appropriate implemented to enhance the services.

6. A suite of metrics have been put in place and are audited every two months. Findings and outcomes are discussed with the resident and family. All actions and learning's are communicated to all staff by Clinical Nurse Managers.

Proposed Timescale: 30/07/2015

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 centre's policy on the prevention, detection and response to abuse had not been reviewed within the last three years.

4. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures

referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
1. The elder abuse policy and training programme has been reviewed and will be made available on Q-Pulse the policy management system.

2. Elder abuse refresher training is ongoing.

3. All staff will receive elder abuse training every two years.

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:
The medication management policy made available to inspectors during the inspection did not include any guidance on the ordering or prescribing of medicines, or on the handling and disposal of unused or out of date medicines.

5. 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:
1. The medication management policy has been updated with the Pharmacist.

2. A copy of the amended medication management policy is now available on each unit and on Q-Pulse the policy management system.

3. In addition, a full multi disciplinary team review of the procedures has taken place and the following recommendations implemented:

- Medications for disposal will be returned daily to Pharmacy.

- The medical records will have the reason for crushing of medications.

- This will also be displayed on the drug kardex.

- The Pharmacist will ensure the medication provided is suitable for crushing.

4. Appropriate training will be provided to all staff supported by HSEland / NMBI ELearning package (Guide to Medical Management).

Proposed Timescale: 30/06/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The medication management policy made available to inspectors during the inspection had no date of implementation or any date of review indicated on the policy.

6. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
1. The medication management policy has been reviewed and updated with the Pharmacist and will be reviewed annually.

2. A hard copy is available on each unit and Q-Pulse the policy management system.

Proposed Timescale: 05/06/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management of complaints policy requires review.

7. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
1. The policy and procedures have been reviewed and updated and is available on Q-Pulse the policy management system.

2. The complaints procedure has been reviewed and a new document devised (Record of Complaint) to include the following:-

1. Name of Complainant 2. Complaint received by
3. Date & Time Received 4. Nature of Complaint
5. Details of Complaint 6. Investigation Process

7. Actions Completed 8. Response Date (5 Days)
9. Complaint Upheld Yes/No 10. Unable to Determine
11. Response Details 12. Resolution
13. Learning 14. Outcomes
15. Appeals Notification 16. Appeals Details
17. Completed By 18. Decision Date
19. Reviewed by PIC 20. Annual Review Date/Initials

3. Audit process has been developed and trends will be actioned and presented to weekly Management Meetings.

Proposed Timescale: 30/06/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Review policy on residents who require additional supervision and ensure it is service specific and fully informs the staff involved with this aspect of service provision.

8. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
1. A policy on "management of residents requiring one to one constant observation" has been devised by the Clinical Nurse Managers, PIC and Provider and is available on Q-Pulse the policy management system.

2. A policy on "guideline for the management of resident's cohorts" has been devised by the Clinical Nurse Managers, PIC and Provider and is available on Q-Pulse the policy management system.

3. Appropriate training will be provided to all staff.

Proposed Timescale: 31/08/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Mandatory training records were not available for inspection by the Chief Inspector on the day of the inspection.

9. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
1. All training records have been compiled in a master "Training Folder" and retained in the education room, are also available electronically

2. An annual training plan has been devised.

Proposed Timescale: 05/06/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed the administration of medicines to residents during medication rounds on various units within the centre and found that some nursing staff were signing the administration record before administering the medicines to the residents, which is not in line with best practice, or professional guidelines. Inspectors also found that the allergies section of some prescription sheets had not been completed to indicate residents' known drug allergies, or if there were no known drug allergies.

10. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
1. Ongoing education is provided to staff on administering of medication to residents in line with best practice supported by HSEland / NMBI ELearning package (Guide to Medication Management).

2. All prescriptions Kardex have been audited and updated with known drug allergies.

3. As part of the Nursing Metrics Medication audits are being carried out every two months to ensure we are in compliance with NMBI guidelines.

Proposed Timescale: 31/07/2015

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:
There was no documented evidence to demonstrate that alternatives to the use of bed rails or any restrictive practices had been considered or trialled.

11. 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:
1. All residents are assessed by the MDT for the appropriate use of restraints.

2. Recommendations and evidence that alternatives were trialled are documented and any use of restraints will be reviewed to ensure the appropriate restraint is in use.

3. The restraint policy has been updated and all staff are been trained on the use restraints in designated centre.

Proposed Timescale: 30/06/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
At the time of inspection all staff had not received recent training in relation to the detection and prevention of and responses to abuse.

12. 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:
1. All staff working in the residential unit will attend refresher training in relation to detection and prevention of elder abuse in 2015, thereinafter 2 yearly.

2. The PIC will ensure all training records are available in the education room and made available to the chief inspector during site inspections.

Proposed Timescale: 31/12/2015

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:
Incidents and accidents including falls were not fully reviewed by the person in charge to include learning from serious incidents or adverse events involving residents.

13. 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:
1. The Risk Management policy has been reviewed and an addendum has been devised for every incident / adverse event to include the following:-

1. Name of Reviewer 2. Risk form received by
3. Date & Time Received 4. Nature of Issue
5. Details of Incident 6. Action
7. Actions Completed by 8. Preventative Measures
9. Learning 10. HSE/BH Risk Assessment
11. Likelihood Scoring 12. Risk Matrix
13. Reviewed by PIC 14. Annual Review Date/Initials

2. This information will be review and feedback will be submitted to the weekly management meetings / MDT meetings.

3. In addition to this the incidents will be reviewed by PIC/Provider using the HSE risk assessment tool.

4. This information will be recorded in a database to identified trends and actioned as required.

Proposed Timescale: 31/07/2015

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:
Prescribed eye drops that required refrigeration were being stored incorrectly at room temperature. Inspectors observed that during some of the medication rounds residents' medicines were being left unattended and unsecured on top of the drugs trolley.

14. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or

supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
1. Prescribed Eye Drops: - The Pharmacist will apply a highlight label "Fridge " to the top of the eye drop box; this will be added to our pharmacy audit check list.

2. Medication Rounds: - Alternative method of safely storing medication during unit rounds is now in place.

3. CNMs will ensure that all staff are updated with medication administration in line with the policy. Medication administration is audited every two months as part of Nurse Metrics.

Proposed Timescale: 05/06/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found an expired medicine, and medicines that were no longer required by residents (including blister packed medicines), that had not been appropriately segregated and returned to the pharmacy for disposal.

15. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
1. A protocol is now in place for medications no longer required or out of date to be returned to the Pharmacy in a timely manner.

2. All staff will be updated on the appropriate practice.

Proposed Timescale: 05/06/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors reviewed a number of medication prescription and administration sheets and identified that the prescriber had not indicated that crushing was authorised for each

individual prescribed medicine. The prescriber must indicate the authorisation to crush on each individual prescribed medicine on the prescription sheet.

16. 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:
1. CNMs will ensure that correct prescribing of medication is completed by the medical team.

2. Medication management will be audited as part of the nurse metrics.

Proposed Timescale: 05/06/2015

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:
Cause of death as notified in NF01 was not submitted when established by the person in charge.

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

Please state the actions you have taken or are planning to take:
1. An amended NF01 will be resubmitted following notification to the unit of cause of death by the coroner's office.

Proposed Timescale: 05/06/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Quarterly notifications not submitted as required within the time frame required by legislation.

18. Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief

Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
1. All notifications will be submitted within the time frame.

Proposed Timescale: 05/06/2015

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:
The investigation methodology and correspondence was not fully maintained by the person in charge.

19. Action Required:
Under Regulation 34(1)(e) you are required to: Assist a complainant to understand the complaints procedure.

Please state the actions you have taken or are planning to take:
1. The "Complaints, Compliment & Comments" leaflet has been revised outlining the policy and appeals process and are available throughout the unit.

2. All staff will receive training on the complaints and appeals process.

Proposed Timescale: 30/06/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of processes in place to implement learning from complaints received was not evident.

20. Action Required:
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
1. The complaints policy and procedures have been reviewed and an addendum document has been devised (Record of Complaint) for every complaint.

2. The record of complaints addendum includes the following:-

1. Name of Complainant 2. Complaint received by
3. Date & Time Received 4. Nature of Complaint
5. Details of Complaint 6. Investigation Process
7. Actions Completed 8. Response Date (5 Days)
9. Complaint Upheld Yes/No 10. Unable to Determine
11. Response Details 12. Resolution
13. Learning 14. Outcomes
15. Appeals Notification 16. Appeals Details
17. Completed By 18. Decision Date
19. Reviewed by PIC 20. Annual Review Date/Initials

3. A complaints audit process has been developed and trends will be actioned and presented to the weekly management meetings.

4. This will formalise an evidence base responce to all complaints going forward.

Proposed Timescale: 31/05/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complainant was not informed of the option to appeal the outcome of their complaint in their response from the person in charge.

21. Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
1. Training has been provided to the Person in Charge in the management of complaints.

2. The "Complaints, Compliment & Comments" leaflet has been revised outlining the policy and appeals process. It is available throughout the unit.

Proposed Timescale: 30/06/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The methodology of a serious complaint was not fully documented by the person in

charge to outline how the facts were established and outcomes determined.

22. Action Required:
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

Please state the actions you have taken or are planning to take:
1.Training has been provided to the Person in Charge in the management of complaints.

2.The "Complaints, Compliment & Comments" leaflet has been revised outlining the policy and appeals process. It is available throughout the unit.

Proposed Timescale: 30/06/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff engaged in clinical audit had not received appropriate training commensurate with their responsibilities in this area.

23. 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:
Training to be provided for CNMs in relation to audit for:

1. Suite of metrics audits:-

• Pressure Area Management • Falls
• Medication Management • Nursing Assessment
• Nursing Care Plans • Invasive Devices
• Restraint Assessment / Monitoring • Environment
• Call Bells • Drinks
• Restraints • Hygiene

2. Quality of life audit.

3. Risk management audit.

4. Safety walk around audit.

5. Complaints audit.

6. Hygiene audits.

7. Catering, Food & Nutrition audit.

Proposed Timescale: 30/09/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Positive and negative findings from audit and review of clinical documentations were not formally communicated during a staff supervision meeting to facilitate learning and improvements.

24. 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:
1. Audit results and action plans will be communicated to all staff at the weekly team meeting held by CNM's and update on actions will be reported and displayed in clinical rooms.

Proposed Timescale: 30/06/2015