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## Woodlands House Nursing Home, Trim Road, Navan, Meath.

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Woodlands House Nursing Home
<b>Centre ID:</b>	OSV-0000186
<b>Centre address:</b>	Trim Road, Navan, Meath.
<b>Telephone number:</b>	046 902 8617
<b>Email address:</b>	woodlandshousenh@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Sandcreek Limited
<b>Provider Nominee:</b>	Fintan O'Connor
<b>Lead inspector:</b>	Catherine Rose Connolly Gargan
<b>Support inspector(s):</b>	Louisa Power
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	21
<b>Number of vacancies on the date of inspection:</b>	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 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 announced and took place over 2 day(s).

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

From:	To:
17 September 2014 09:00	17 September 2014 18:00
18 September 2014 09:30	18 September 2014 19:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 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 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This monitoring event consisted of two days and was announced. The second day of inspection was scheduled for the purpose of completion of an application to vary conditions of the centre's current registration to increase maximum occupancy from 22 to 34 residents. This was facilitated as a result of a new extension located to the back of the existing centre. However, following discussion with the provider and two directors, inspectors completed a tour of the new extension and observed that all matters in relation to the building work were not at a completed stage. Therefore the variation inspection was suspended and the provider was advised to notify the Authority on full completion of all outstanding building matters in relation to the new extension. The centre premises have been the subject of documented on-going non compliance with the Regulations and the National Standards, in inspection reports and action plans developed by the Authority since September 2010 with regard to areas of risk and the negative impact of the current layout/structure on residents residing in the centre including on their privacy, dignity and independence. The last

inspection in July 2014 was triggered in response to information regarding the care and welfare of residents in the centre which was generally substantiated. Four outcomes were inspected in, three of which constituted major non compliances with the legislation including documentation to be maintained and held in the centre, health and social care needs and medication management procedures. A regulatory meeting was convened by the Authority with the provider/person in charge and the two directors of the company on 30 July 2014.

Fourteen outcomes were inspected on this inspection, of which eight constituted major non compliances and five constituted moderate non compliance with the requirements of the legislation and national standards on this inspection. An immediate action plan was issued to the provider/person in charge at the end of this inspection referencing lack of referral of residents for behavioural and physiotherapy expertise and inadequate evacuation arrangements in the event of a fire in the centre. The provider/person in charge provided supporting evidence of her immediate response to same.

Areas of major non compliance found on inspection in July 2014 were not adequately addressed based on findings of this inspection regarding the healthcare of residents, and documentation to be completed and maintained in the centre. Newly identified areas of major non compliance with the Regulations found on this inspection included governance and management, aspects of health and safety and risk management including fire safety, failure to forward mandatory notifications to the Chief Inspector, safeguarding and safety in relation to restraint management, the layout and design of the premises and the arrangements in place to meet the privacy and dignity needs of residents. Areas of moderate non compliance included; medication management, complaints management, non provision of an adequate workforce, food and nutrition and arrangements in place for an absence of the person in charge.

Residents spoken with told inspectors that they felt safe and were complimentary of the staff caring for them. Staff interactions with residents were observed by inspectors and found to be warm, patient, helpful and kind.

The Action Plan at the end of the report identifies mandatory improvements required to meet the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for the Older People in Ireland

**Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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):**

No actions were required from the previous inspection.

**Findings:**

The statement of purpose document was reviewed by inspectors. The statement of purpose described the aims, objectives and ethos of the centre, detailed the facilities and services provided for residents and was reflected in practice in the centre. It did not contain all required information in relation to the matters listed in Schedule 1 of the Regulations. The information provided was not accurate and required review in terms of staff numbers and maximum number of residents to be accommodated. Deputising arrangements in the absence of the person in charge were not stated as required by the Regulations.

**Judgment:**

Non Compliant - Minor

**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 that identified the lines of accountability and authority. Susan Walsh is the provider nominee and person in charge of the centre. She is supported in her role by the two other directors of the company, one of which; Robert Walsh actively participates in the day to day management of the centre. Inspectors found areas of major non compliance with the Regulations and Standards on all three inspections this year to date in relation to the suitability of purpose of the

premises. A new build is nearing completion located to the back of the centre which the provider assures the Authority will address non compliance in this area. However, the effectiveness of the management systems in operation in the centre was not adequate and the findings of inspections did not confirm that the service was safe, appropriate, consistent and effectively monitored. This is evidenced by findings of on-going major non compliances with the Regulations and Standards. Inspectors found repeated major non compliances on this inspection which were notified to the provider/person in charge following inspection in July 2014, in relation to the healthcare of residents, documentation to be maintained in the centre and medication management procedures. These areas and additional areas of major non compliance with the Regulations were found on this inspection to include risk management and fire safety and restraint management. An immediate action plan was given to the provider/person in charge at the end of this inspection by inspectors referencing lack of referral of residents for behavioural and physiotherapy expertise and inadequate fire safety procedures.

While aspects of the quality and safety of care and the quality of the residents' experience in the centre were monitored. The inspector reviewed evidence of some audits. While key information was collated in data collection, not all information analysed informed improvement, for example; areas of non-compliance found with medication management on inspection, review of restraint use did not provide evidence of positive outcomes and quality improvement for residents. The review was incomplete and did not impact on the use of buxton chair restraints which had a negative impact on the freedom of residents and are a documented hazard to the safety of users.

**Judgment:**

Non Compliant - Major

***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:**

Inspectors reviewed documentation relating to staffing rosters, policies and procedures, documentation to be held in respect of the person in charge and for a sample of staff and documentation to be held in respect of each resident including the directory of residents, care plans, medical and allied health professional reviews. Major non compliances were identified in the reviewed documentation on inspection in July 2014

and were detailed in feedback meetings, a regulatory meeting, reports and action plans to the provider/person in charge following these inspections.

Staffing rosters were reviewed on this inspection and were inadequate in some areas as discussed in outcome 18 of this report.

Although prescribing, dispensing, administration and recording of medications were found to have improved from the last inspection in July 2014, new areas were identified regarding medication management on this inspection that were not in compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. These findings are discussed in outcome 9 of this report.

Some residents' care plan documentation did not reference a documented care plan for each of their identified needs and as such placed their health and well-being at risk of deterioration. Referral of residents to advise and support their healthcare in terms of physical and mental health needs was not adequate and was the subject of an immediate action given to the provider/person in charge at the close of this inspection. Residents' care plan documentation was not centre-specific. Records were not maintained in relation to some residents' pain management.

The statement of purpose document available in the centre was not accurate. The directory of residents was missing some items of required information. Not all notifications under regulation 31 of the legislation were forwarded to the Chief Inspector. Records regarding fire evacuation drills and staff training were incomplete.

While policies and procedures were available to guide practice, many required review to correct hand written entries, Some policies were referenced with review dates for a number of year however, there was no evidence<sup>3</sup> to support when additions or changes were completed. The risk management policy required review and a policy on management of the risk of self-harm was absent. Some additional information was required in the policy on protection to inform referral procedures.

**Judgment:**

Non Compliant - Major

***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:**

Arrangements were not in place for management of the centre by a suitably quality deputy in the event of the person in charge being absent. A notification was not

forwarded to the Chief Inspector to reference the change in the deputy person in charge as detailed on the centre's registration certificate as a person participating in management of the centre. No arrangements were in place or notification forwarded to the Authority of a replacement deputy person in charge.

**Judgment:**

Non Compliant - Moderate

**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):**

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

**Findings:**

There was a policy in place to inform prevention, recognition and management of abuse implemented in January 2009 and reviewed annually with last review dated for 2014. However, hand written additions were made in this document which may pose a risk of misinterpretation. These additions were not dated. No referral details for the Senior Case Worker in Elder Abuse were included. This was an action required from inspection in April 2014. Staff spoken with by inspectors were knowledgeable on the centre's protection procedures and with responding to disclosures however some were unaware of the referral procedures outside of the nursing home if required. Residents spoken with told inspectors that they felt safe and were complimentary of the staff caring for them. Staff interactions with residents were observed by inspectors and found to be warm, patient, helpful and kind. Measures to protect persons making disclosures was described in the centre's protection policy.

There was a restraint management policy available dated June 2014, which was reviewed by inspectors. There were two versions available in addition to a copy of the Health Service Executive Policy 2010. This finding may cause confusion and requires review to ensure a definitive document is available to inform practice in the centre. The person in charge/provider maintained a restraint register which was viewed by the inspector. Review of need for restraint was documented on a three monthly basis in residents' care plans and was recorded weekly in the centre's risk register. There was evidence from review of the restraint register of action taken to reduce restraint use in the centre with documentation supporting successful removal of a number of bedrails. However, restraint use was found not to be in line with best practice in terms of release schedules, consultative procedures and adequate risk assessment of use of chairs with fixed tables fitted including buxton chairs. Residents with bedrails had a bedrail risk assessment completed. Those assessed as being at risk of injury used covered bedrails. The inspectors observed that three residents used chairs with detachable tables fixed in

place, one of which was tilted. Staff told inspectors that one resident was at risk of falling and the fixed table was employed as a control to mitigate risk of same. Adequate assessment of need for restraints, restraint monitoring and release procedures were also not in place for these residents. Review of one resident's documentation in relation to use of this type of restraint stated that the fixed table was to be removed during the time when the activity co-ordinator was facilitating recreational activities. Inspectors observed that this was not done at any stage during same.

Not all staff files reviewed were in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. There was confirmation of An Garda Siochana vetting missing for one staff member.

**Judgment:**

Non Compliant - Major

***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):**

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

**Findings:**

A safety statement dated January 2014 was made available to inspectors, the document reviewed contained a copy of the health and safety authority document 'Health and Safety at work in residential care facilities' and while this accredited document may assist with informing best practice, the information in relation to health and safety arrangements in the centre described within the safety statement was not comprehensive. A copy of a Health Service Executive (HSE) document also contained in the folder advised on waste management procedures but was not centre specific. The document alluded to identification of hazards by conducting periodic audits. The methodology of these audits was not clear or whether findings informed hazard mitigation activity. There was information referencing formation of a health and safety team, the membership of which included a staff nurse, carer and a company director who also participated in the management of the centre. There was confirmation from minutes that an inaugural meeting of this team had taken place. The minutes confirmed that a decision was taken to hold quarterly meetings; and while a meeting was held on the 24th May, there was no minutes of proceedings readily available. There was no evidence to confirm that actions to be taken as identified in the inaugural meeting to mitigate risks were completed. For example, a risk assessment on safety of portable heater/radiators in bedrooms.

The risk management policy was not adequate. It did not reference arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents. Not all hazards throughout the centre were identified and risk assessed and those hazards identified did not detail comprehensive measures and

actions to control risks posed. For example, trip hazard on exiting the double doors into the enclosed courtyard, uncontrolled access to the laundry/slucice areas, risk of injury from the chair lift on the stairs, risk posed by the chair lift seat while the security catch was broken, trip hazard posed by uneven floor surface at the junction of two corridors, absence of natural light in two bedrooms, storage of clinical supplies in the wardrobe of a twin bedroom and an unlocked wooden shed in the courtyard containing hazardous chemicals. Controls were documented to control the risk of abuse, unexplained absence of a resident, accidental injury to residents, visitors and staff and aggression and violence. The risk of self-harm was not identified. The Authority was forwarded a notification referencing an incident where two vulnerable residents left the centre unaccompanied on 08 June 2014. An investigation of the incident was carried out with measures identified to mitigate risk of reoccurrence. However, the causal factor for this incident and controls identified were not documented in the hazard/risk register.

The inspectors found evidence of procedures and practices in the centre that were not consistent with standards for the prevention and control of healthcare associated infections published by the Authority. A standardised cleaning procedure was not assured as colour coding of cleaning equipment was not consistently in line with the recommendations of the National Cleaning Manual 2006 to ensure that specified items are not used in multiple areas, reducing the risk of cross-infection. Two different cleaning processes were used in the centre with flat mopping in one area and use of mop heads in rest of the centre. Throughout the days of inspection, two unattended buckets of cleaning solution were observed. While inspectors were told that mop heads were changed following cleaning of a specified area, inspectors observed mop heads still attached to the handles in storage on the outside of a door in the courtyard. There was no designated cleaner's room. Used laundry was transported in uncovered laundry skips across the courtyard by staff to the laundry area. Colour coded linen bags were not used in line with recommendations. Clinical storage was placed in a wardrobe in an occupied twin bedroom. Cleaning staff were not available at weekends.

Procedures and practices in the sluice and laundry did not meet best practice infection control and prevention standards.

The laundry was located in a room accessible from the sluice room. There was an absence of natural light or adequate ventilation in the laundry room. There were inadequate arrangements including worktop space for segregation of soiled and clean linen. A hand hygiene sink was not available. The sluice area also served as an area for staff changing and storage of staff clothing. Two waste bins were located in this area, one of which was a small yellow healthcare risk waste bin. This bin was completely obstructed by a linen trolley. Urinals were not stored inverted in the absence of an appropriate storage rack, one urinal was placed on a window ledge behind the sink and a second urinal was soaking in the sink. While commodes were in use in the centre and were stored in residents' bedrooms, there was no bedpan decontamination unit available. A flushable sluice hopper was available. Floor surfaces were unclean and a loose tile was in place to cover the surface of the window ledge. There was no hand hygiene sink available other than the equipment cleaning sink which did not have hand hygiene soap insitu.

Inspectors were not satisfied that these arrangements constituted adequate assessment of residents' needs, infection prevention and control or appropriate waste management

practices. Staff spoken with were knowledgeable with regards to use of personal protective equipment such as aprons and gloves and the importance of colour coding. A policy on infection control was in place but was not sufficiently comprehensive to guide staff and did not reference the arrangement for managing one resident in terms of waste disposal and infection prevention and control procedures. Procedures for disposal of one resident's faecal waste was revised since the last inspection of the centre, however inspectors were not satisfied that the revised arrangements were in line with best practice infection prevention and control and waste management standards. Inspectors found that one resident continued to be encouraged to dispose of faecal excrement in an open waste bin by their bed. The arrangement in place involved transportation of this waste to the sluice and disposal of same in a healthcare risk waste bin. There was no such waste bin in the resident's bedroom. A two hourly checking arrangement was in place to ensure this waste was disposed of and the floor was free of urine spillage which inspectors observed and was confirmed by staff spoken with was completed more frequently. Inspectors visited this room on two occasions and found the area to be clear of urine spillage and odour free. The resident was alert and awake, resting in bed and watching cricket on television. The provider/person in charge advised the Authority that she had received the input of an infection control nurse specialist and a continence specialist with managing this situation by telephone.

Inspectors reviewed fire safety arrangements in the centre and found that they were not of an adequate standard to ensure that residents could be safely evacuated to a place of safety in the event of a fire in the centre. Inspectors found that while residents had a fire evacuation sheet fitted on their beds, they did not have their individual evacuation needs assessed in terms of staffing and equipment requirements including evacuation and medical equipment that should be used or accompany them in the event of their evacuation being required. While staff training in fire safety and evacuation was done, 50% of staff spoken with did not have a basic knowledge of the evacuation arrangements in the centre. Although documentation referenced a fire drill having taken place on the 02 July 2014 that addressed day and night evacuation procedure, there was no evidence that the adequacy of staffing levels at night were adequate to meet the evacuation needs of residents including residents who remained in bed or had behaviour that challenged. Fire safety training for staff was delivered by the provider/person in charge and a director of the company. There was no evidence that either had the necessary accredited fire training to deliver same. The safety statement referenced the centre as being divided into five fire zones; however no reference was made to in the fire evacuation plan. The procedures to follow in the event of fire were not adequately displayed. Not all fire evacuation signage was illuminated and an evacuation sign over an exit door into a new build located at the end of a corridor without natural light was not visible. Directional signage was missing from one corridor. Although fire exits were secured by electromagnetic units that disengaged on activation of the fire alarm, gates permitting exit to the fire assembly area located at the front of the building were locked with a chubb-type lock in both cases effecting entrapment in the courtyard on one side and in a pathway on the other side of the building. One gate opened into the courtyard into a fire assembly area signposted in the courtyard. Inspectors were told that the key for this gate was kept in a wooden shed in the courtyard; this was documented in the documentation referencing fire procedures. Inspectors found this wooden shed, which was accessible to vulnerable residents unlocked; the contents included hazardous chemicals including weed-killer. The designated smoking area was not closed off from

the rest of the centre. A resident was observed smoking and was not adequately supervised by staff. There was also a risk posed to other residents and staff of secondary smoke inhalation which was not assessed.

**Judgment:**

Non Compliant - Major

***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:**

The centre-specific policies on medication management were made available to the inspectors which had been reviewed in June 2014. The policies were comprehensive and evidence based. Records were made available to the inspector which confirmed that staff had read and understood the policy.

Medications were supplied by a local community pharmacy for long stay residents. The residential centre had entered into a collective service agreement with the community pharmacy. However, documentation and consent forms made available to the inspectors did not confirm that all residents wished to participate in the collective agreement. The collective agreement made available to the inspectors was signed in June 2012 by the pharmacist and the provider outlined the pharmaceutical service provided to staff. The agreement did not describe the provision of pharmaceutical care to residents by the pharmacist in line with guidance issued by the Pharmaceutical Society of Ireland.

The inspectors observed that, for residents admitted on a respite basis, a comprehensive medication history was obtained on admission using a number of sources. Residents admitted for respite care were asked to bring in their own medicines from home dispensed by their pharmacist of choice and nursing staff were seen to confirm the medication to be correct.

The inspectors noted that all medications were now stored securely. A lock had been fitted to the medication refrigerator since the last inspection in July 2014. Medications requiring refrigeration were stored appropriately. The temperature of the medication refrigerator was monitored and recorded daily. The date of removal of an insulin pen from the refrigerator was recorded.

Storage of controlled drugs was safe and in accordance with current guidelines and legislation. The inspector saw records that a nurse from each shift completed the count of controlled drugs at the changeover of shifts in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais. However, based on a sample of entries, the inspectors noted that not all transactions relating to controlled drugs were

entered into the register, in line with the Misuse of Drugs Act 1988.

Medication management training was facilitated and nursing staff with whom the inspectors spoke outlined that medication administration was carried out by nursing staff only. Nurses demonstrated knowledge and understanding of professional guidance in medication management. The inspectors confirmed with nursing staff that the practice of secondary dispensing had ceased.

Staff reported and the inspectors saw that it was not practice for staff to transcribe medication and no residents were self-administering medication at the time of inspection.

Medication management audits were completed monthly and countersigned by the pharmacist. While audits were carried out on a number of areas the inspector was not satisfied of the validity of the audits as the audits did not identify issues which the inspectors identified during the inspection. This finding is also discussed in outcome 2 of this report.

The use of chemical restraint was in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health. The inspector saw documented evidence that potential episodes of restraint was considered only if the potential benefit of restraint to the resident, and the risk involved if restraint is not used, outweigh the possible negative effects on the resident subject to restraint. The inspector noted that records for residents subject to chemical restraint included a consideration of all alternative interventions.

A full assessment of the resident prior to each episode of chemical restraint, monitoring of residents during any episode of chemical restraint, adverse events resulting from chemical restraint and a detailed record of each episode of chemical restraint were documented.

The inspectors noted that medication prescription sheets were current and contained all of the required elements. Medication administration sheets identified the medications on the prescription sheet, contained the signature of the nurse administering the medication and allowed space to record comments on withholding or refusing medications. The times of administration matched the prescription sheet.

Staff spoken with by the inspector outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. However, the inspectors noted that the expiry dates were not available for short term medications dispensed out of their original packaging. Therefore, staff could not identify when these medications were due to expire.

This finding posed a risk to residents.

**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:**

A record was maintained of all incidents that occurred in the centre. A notification of a serious injury to a resident was notified to the Chief inspector as a quarterly notification and as the resident concerned sustained a fall and required transfer to hospital for review, a notification of serious injury is required.

A notification referencing an incident where two vulnerable residents left the centre unaccompanied requires revision to document this incident for each resident individually and notify the Chief Inspector accordingly.

A notification was not forwarded to the Chief Inspector to reference the deputy person in charge detailed on the centre's registration certificate as a person participating in management of the centre.

**Judgment:**

Non Compliant - Major

**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):**

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

**Findings:**

The inspector viewed six residents' documentation and care plans. Care plan documentation was pre-printed and was individualised by adding interventions and/or by selecting the most appropriate intervention option presented from a series of pre documented options available. The documentation confirmed that an assessment of needs was completed on admission with associated care plans describing required interventions to meet needs identified. A record was in place confirming that care plans

were reviewed at a minimum of every four months. Reviews were done in consultation with the resident or their significant other. Inspectors found from the care plans reviewed that not all residents' needs identified had an associated care plan in place to inform required care interventions. For example, a resident with weight loss of 6.7kg in a 3 month period did not have this finding identified in a care plan to inform interventions to be taken. Daily care plan progress notes were not adequately linked to care plans and as such were not informative regarding effectiveness of care plan interventions.

While there was evidence that residents had access to a dietician and GP services, access to behavioural support services, physiotherapy, occupational therapy, speech and language therapy were not adequate. Recent referral in August 2014 of a number of residents to a continence advisory specialist was evidenced with consultations completed for some residents.

There was evidence to support that the absence of adequate physiotherapy and behavioural support services was negatively impacting on the care and welfare of some residents in the centre. For example one resident admitted in 2010 was found on this inspection to be bed bound with severe contractures of hands and feet. While there was documented input from physiotherapy services post admission, this resident's documentation did not support all reasonable efforts were made to involve this service or implementation of an exercise programme to maintain this resident's limb function and mobility. While there was some reference to limb stretching and mobility exercises while immobile this was not clearly stated. Physiotherapy services were not involved in risk assessment for residents using the chair lift to ascend and descend stairs or to assess the resident who resides in an area accessible by three stairs without lift access. Physiotherapy specialist advice was not sought for residents with deteriorating mobility needs or for residents who fell in the centre. One resident had three falls in the past 12 months.

Findings by inspectors during inspection in July 2014 in relation to a resident presenting with challenging behaviour and associated action plans developed from findings forwarded for response to the provider were also reviewed. Inspectors found that a continence advisory specialist assessment was completed on the 25 August 2014. However, an adequate behavioural approach had not been made on behalf of this resident to date as recommended by psychiatric services in June 2013. Continence and elimination management continued to be described as posing an ongoing difficulty for this resident. The practices used to support the individual with elimination needs and associated difficulties were inappropriately managed and did not ensure the care, welfare and support of the resident. The negative outcome manifest by symptoms of this resident's medical diagnosis in the absence of reasonable efforts to involve behavioural psychology specialist input in the management of same continues to severely compromise this residents socialisation, health and dignity.

Pain assessment tools were not routinely used for managing residents' pain. A resident with a painful joint condition told the inspector that pain was a key factor in preventing mobility. The resident remained in bed throughout the days of inspection. There was inadequate evidence of a programme in place or reasonable efforts made to seek specialist physiotherapy or occupational therapy advice or assessment to assist this resident with sitting out of bed or with socialisation. While there was a glass panel fitted

between this resident's bedroom and a corridor, the resident was observed by inspectors to reside in a bedroom without windows to the exterior of the building, a window in the en-suite was boarded up to facilitate building work on the new extension.

While staff including the activity co-ordinator knew residents well, residents' care documentation contained little evidence of a meaningful programme to meet their social care needs. This was most evident with residents who remained in their rooms. This finding is discussed in Outcome 16 of this report.

**Judgment:**

Non Compliant - Major

**Outcome 12: Safe and Suitable Premises**

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

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The centre premises have been the subject of documented on-going non compliances with the Regulations and the National Standards, in inspection reports and action plans developed by the Authority from September 2010 with regard to areas of risk and the negative impact of the current layout/structure on residents residing in the centre. The provider advised the Authority that a new extension would address all issues identified to date. The Authority were informed that the new 30 bedded extension was completed and ready for variation inspection. However, a variation inspection scheduled for the second day of this inspection was suspended as inspectors found that all work was not completed to a finished state and all furnishings and fittings were not in place in this newly built extension. Therefore inspectors could not complete the inspection at this time.

The design and layout of some parts of the building do not meet their stated purpose due to;

- No windows to the external were fitted in room 15 and 16.
- Windows boarded up in one residents' bedroom numbered 11 and en-suites boarded up in rooms numbered 11, 15 and 16 resulting in no natural light or ventilation.
- Glass panels in the adjoining wall of a corridor and bedrooms numbered 15, 16 and 17 did not ensure the privacy of the residents residing in these rooms.
- Glass panel in wall between a corridor and a communal shower/toilet did not ensure the privacy of residents using this facility was respected.
- single bedroom on the 2nd floor, accessible by three steps did not have lift access.
- Floor covering in room 12 was severely damaged and not of a standard to facilitate

adequate cleaning.

- No cleaner's room
- Sluice area is not fit for purpose and does not meet the minimum requirements as stated in the standards.
- Laundry is an inner room in the sluice; it is not adequately ventilated and lacks adequate space for segregation of soiled and clean linen, does not have an ironing facility and was not fit for the purpose of laundering residents' clothing.
- Smoking area was not closed off from the rest of the centre and exposed residents, staff and visitors to secondary smoke risks.
- Inadequate secure storage and preparation facilities for residents' medications and clinical supplies. Residents' clinical stock was stored in part of a wardrobe used by two residents in a twin bedroom.
- Residents do not have access to a garden. An inner courtyard for use by residents had unsafe surfaces, an oil tank which the provider said was no longer used, an unlocked wooden shed containing hazardous chemicals including weed killer and was an access area to the kitchen and sluice.
- En-suite facilities blocked by commodes for example a commode was stored in the en-suite in bedrooms 11 and 16.
- Lack of storage for residents' equipment including hoists, wheelchairs stored on a corridor and commodes stored in bedrooms while the residents in those bedrooms were using communal facilities.
- There was evidence of damp on the ceiling of a twin bedded room occupied by residents.
- Access to a hand hygiene sink was obstructed by a television placed in front of it in a twin bedded room.
- The layout of one resident's bedroom did not ensure privacy was respected as the head of the bed was in front of a large window occupying most of the height of the wall.
- There were no pedestrian footpaths in place along the entrance roadway or around the front of the building.
- Car parking provided was immediately in front of the building and was limited to two to three cars necessitating car manoeuvring in close proximity to the front door. However, inspectors were told that this restriction was a temporary arrangement to facilitate building works.
- Suitable changing and storage facilities for staff were not available.
- There was insufficient numbers of toilet and shower/bathroom facilities for residents.
- Adequate communal accommodation was not provided for residents.

The inspectors were informed by the provider that provisions have been made for the all of the aforementioned non compliances in the new build and will be inspected by the Authority on notification that the new build is fully completed and ready for occupation by residents.

**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):**

No actions were required from the previous inspection.

**Findings:**

A complaints policy was available to inform the procedures to be followed in the event of a complaint. Inspectors reviewed same and found that an appeals process was not adequately documented. No complaints were logged since June 2011 in the complaints log. The person in charge told inspectors that no complaints were received in this period. Review of the complaints documented referenced investigation of same and details of actions taken to resolve dissatisfaction. However, the satisfaction of the complainant with the outcome of investigation was not consistently documented in each case or information on an appeals process was not communicated to the complainant.

**Judgment:**

Non Compliant - Moderate

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector observed the lunchtime meal, which was served to residents either in the dining room, communal sitting room or in the residents' bedrooms. Residents' choice of dish was confirmed with them when serving their meal. A menu was available on each table and was displayed on the wall on entering the dining room. The inspector observed that there were two choices of hot meal available, chicken and beef stew with two vegetable choices and gravy was served separately to facilitate residents' taste and choice. However, inspectors observed that while rice pudding was offered as desert on the menu, residents were offered jelly and ice cream. One resident was noted to decline same and was offered a banana which she also declined and agreed to have biscuits. Staff were observed to assist residents discreetly. Jugs of fluids including milk and water were placed on dining tables, on a side board in the dining room, the sitting room and in residents' bedrooms during the day. Inspectors observed that while fluids were provided as stated, a water cooler dispenser was located in an area outside the inner front door and as such was not accessible to residents. Adequate condiments were available on each table including butter. The lunch mealtime was an unhurried social occasion and residents who spoke with the inspector were complimentary of the food and meals provided. The inspector observed that all residents who chose chicken as their main

course were served same pre-chopped. The provider/person in charge told inspectors that this was done to assist residents with chewing as many found this process tiring. However, the inspector observed that residents were served modified consistency meals on assessment by staff without evidence of choice and not supported by referral and assessment by speech and language therapy expertise to ensure the level of modification was adequate or appropriate.

A policy document was available to inform staff with meeting the nutritional and hydration needs of residents. The document referenced an accredited nutritional assessment tool and management of dysphagia and choking. Monthly weights were recorded for residents in addition to calculation of their BMI (basal metabolic rate) to ensure their needs were met. Staff training for 2014 included attendance by some staff at training on nutrition in wound healing, nutrition and falls, diabetes, dysphagia and training on use of the nutritional assessment tool used. A dietician was available to assess and advise on the nutritional needs of residents and consultation was referenced in some residents' care documentation. Recommendations made by the dietician were also made available to the chef.

**Judgment:**

Non Compliant - Moderate

***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 had access to an advocate and also the 'friends of Woodlands' who visited weekly advocating on their behalf if required. The activities coordinator knew the residents well. She met with new residents to gain knowledge of their preferences as did the cook in relation to their meals and snacks. The activities person celebrated special occasions for residents such as birthdays. Some residents had personalised their bedrooms with photographs and possessions. The communication needs of residents with diminished eyesight were met with access to the optician who assessed residents' needs by visiting them in the centre. One resident who required referral to an ophthalmologist was facilitated to avail of this expertise. Care plans reviewed referenced assessment of communication needs with concomitant care plans developed for a number of residents with conditions affecting their sight.

There was some evidence that residents were consulted about how the centre was planned and run. One resident told inspectors that he would be moving to a newly built

room but had not visited the new build or was consulted regarding the décor of his new room. A floor plan of the new build was displayed in the hall of the centre and staff spoke to residents about same.

While staff closed doors and curtains while providing personal care for residents, inspectors observed that curtains reviewed were not of a quality to fully obstruct view and preserve privacy when closed.

Panel windows in an adjoining wall with a corridor between three bedroom walls and a communal shower/toilet permitted view of the residents within these facilities. This finding did not ensure the privacy needs of residents were met.

Commodes were stored in a number of residents' bedrooms during the days of inspection while the residents residing in the bedrooms used communal facilities in the centre. The impact on the dignity of residents concerned had not been considered or assessed. While residents told inspectors that they appreciated the convenience of having a commode nearby at night in the absence of en suite facilities in some bedrooms, they were not required during the day.

The procedures in place for managing one resident with challenging behaviour that impacted negatively on his elimination activities did not ensure that all aspects of his dignity needs were respected.

No visitor's room or second sitting area to enable residents to meet their visitors in private outside their bedroom was provided, however inspectors were told that residents often used the dining room to meet visitors in private.

Residents' care documentation contained little evidence of a meaningful programme to meet their social care needs. This was most evident with residents who remained in their rooms. There was inadequate assessment of their preferences on how they would like to spend their time and documentation to support positive outcomes from participation in activities offered especially for residents who remained in their rooms. An activity co-ordinator worked in the centre two hours each day from Monday to Friday each week. A programme of activities were facilitated in the sitting room available including floor games, watching DVDs, bingo, reminiscence, reading newspapers among others.

**Judgment:**

Non Compliant - Major

***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:**

Inspectors spoke with staff, throughout the days of inspection and found them to be knowledgeable regarding residents' needs and their preferences. Staff spoke about residents respectfully. They were aware of the reporting structure within the centre and were able to identify the person in charge as the head of the team. A deputy person in charge was not identified as required. Staff were documented on the duty rota by their full name on this inspection which was an action plan developed from the last inspection in July 2014. There was no lap-over time scheduled on the duty rota for staff hand-over. This finding does not assure residents needs are communicated in a structured way to ensure continuity of care.

The inspectors was not assured that there was adequate staff on duty based on findings on this inspection. Inspectors found that while staff called into the sitting room at frequent intervals during the days of inspection, there were times when residents were unsupervised. Two residents in the sitting room during the day were restrained in buxton type chairs with fixed tables fitted, one of which was in a tilted position. Inspectors were told by staff that the restraints were in place as one resident was at risk of falling. This finding was not an adequate alternative to staff supervision. Inspectors were also not assured that night - time staffing levels were adequate to meet the evacuation needs of residents in the event of a fire in the centre as a simulated fire evacuation drill did not clearly take account of the numbers of staff on night duty and the needs of residents during this time. A review of notifications forwarded to the Authority in for the notification period ending 31 July 2014 evidenced that 70% of resident falls occurred between 21:30hrs and 03:30hrs, one of which required transfer to hospital for review. In addition, two vulnerable residents left the centre unaccompanied at 19:45hrs when there was three staff on duty which reduced down to two staff at 20:00hrs until 08:00hrs. A staff member was referenced on the duty rota as working continuous night duty, there were no supervision arrangements evident including appraisal for this staff member. The provider/person in charge told inspectors that she was available out of hours for advice and support if required.

There was evidence that staff had not completed mandatory training as required. Training records were in list format referencing fire safety training, The information in this format did not readily inform training needs. The was also a finding from the last inspection in July 2014. The inspectors viewed eight staff files. Not all were in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009. There was confirmation of An Garda Siochana vetting missing for one staff member.

**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:***

Catherine Rose Connolly Gargan  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



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

<b>Centre name:</b>	Woodlands House Nursing Home
<b>Centre ID:</b>	OSV-0000186
<b>Date of inspection:</b>	17/09/2014
<b>Date of response:</b>	24/12/2014

### Requirements

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

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

#### Outcome 01: Statement of Purpose

**Theme:**

Governance, Leadership and Management

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

The statement of purpose document did not contain all required information in relation to the matters listed in Schedule 1 of the Regulations.

**Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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

Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose has been updated by the Provider, in regards to staff numbers, maximum number of persons to be accommodated and deputising arrangements in the absence of the person in charge and amended to reflect the current situation of the Centre.

The Statement of Purpose had been amended to reflect the overall centre in respect of the Application to Vary and this amended SOP had mistakenly been put into circulation.

**Proposed Timescale:** 24/12/2014

**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:**

Management systems did not ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Action Required:**

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

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

Note in General there is a comprehensive audit system in place. Additional audits will be added to review medication management by nurses. In addition revisions to audits will be more comprehensively documented and changes as a result of implementation will be noted.

Resident related systems such as medication management are being reviewed by the PIC to ensure they are aligned with best practice. Any amendments necessary will be undertaken by the PIC.

A review of general management systems has begun. This will be undertaken by the General Manager and Directors of the Provider. This review will focus on non-medical related systems such as Risk Management, Fire Safety. Since the inspection a Fire Consultant has reviewed the Centre with particular reference to evacuation and his report has been sent to the Authority. All items in his report have been addressed.

The General Manager, PIC and Provider director are reviewing documentation and record keeping systems. This will help to ensure all documentation is comprehensive and links are established where appropriate between different documents. It is expected that this full review will be completed by Dec 31st.

To support this process the Provider is purchasing a new PC based system to further enhance record keeping and monitoring. This system will ensure a more detailed and comprehensive documentation management system is available to all staff. Review of systems and decision on particular version to be made by 15th November. Installation will commence shortly thereafter and will be complete by Dec 31st. Additional time will be required to fully update system with all records and to allow for comprehensive staff training. Given the Christmas break it is envisaged the system will be fully functional by Jan 31st. In the interim the documentation review will continue to implement enhancements.

To further support the PIC in the area of documentation management and control the Provider will recruit an additional administrative support staff member to ensure consistency and completeness in documentation, records , and management of information on an ongoing basis.

It is expected position will be filled and the additional staff member in place , subject to satisfactory Garda vetting, by Dec 31st.

The following items are being addressed as indicated:

1) Suitability of premises, as acknowledged the Provider has constructed a new building. The new building has 30 bed spaces. This building is not an additional 20 beds it will bring the centre number from 22 – 34 beds overall . Contrary to the report stating the building is a 20 bed extension, it is in fact replacing all existing beds with new beds.

2) This building will eliminate all current bedrooms on the ground floor of the existing building.

The new building is currently finished and awaiting registration. It is envisaged that the building would be in operation prior to December. It is intended that all existing residents would move to new rooms in the new building according to their choice.

Thereafter the old building will be renovated. This renovation will take approximately 4-5 weeks. Therefore depending on the date of registration of the new building the entire project will be finished 4-5 weeks later.

3) The General Manager and Provider Director have begun a review of Risk Management to ensure that all elements of Regulation are fully included. A new Risk Management Policy is being developed . This will be completed by Dec. 30th.

4) Fire safety, a fire consultant has already reviewed the premises His report was submitted to the Authority He found no major issues with fire safety training, fire fighting equipment or evacuation procedures. Three minor requirements regarding moving a flower pot , putting a key in a break glass box and relocating an assembly point sign have been completed.

5) Additional items required by the Fire Officer from Meath Fire Service following an inspection have also been implemented.

Ongoing fire safety training has is being undertaken with particular emphasis on the new building. This training has been and is being conducted by a specialised safety training company.. This training places particular aspects on dealing with bed bound residents, residents with challenging behaviour, evacuation procedures especially in the new building and dealing with residents whose clothes may have caught fire.

**Proposed Timescale:** 31/12/2014

**Theme:**

Governance, Leadership and Management

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

The inspectors were not satisfied of the validity of the medication management audits as the audits did not identify issues which the inspectors identified during the inspection.

**Action Required:**

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

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

The PIC has made amendments to the audits to capture issues identified by the inspectors relating specifically to expired medicines, entries to Drugs Register.

A new system of cross checks whereby PIC and other nurses will cross check audits is being introduced on a weekly basis to ensure the quality of audits is enhanced.

In addition to the above the PIC is undertaking a review of the full medication management system to ensure it is comprehensive and in accordance with regulations and standards. This review will be complete by the end of November 2014.

The PIC will undertake task specific audits eg watching the nurse completing their meds round noting and checking each step.

**Proposed Timescale:** 30/11/2014

**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:**

While policies and procedures were available to guide practice, many required review to comprehensively advice practice in the centre.

**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:**

All existing policies and procedures are being reviewed individually by either the PIC, the General Manager or Provider Director. This exercise will be completed by December 30th with some being completed earlier.

Each policy will be reviewed to ensure it is in line with the requirements of schedule 5. To be completed by December 30th. Policies will be amended where necessary.

The PIC and other nursing staff will review all Care Plans and identify information which will enhance same appropriately. This exercise will be completed by November 30th.

While all Care Plans are subject to formal review every four months a new procedure to be introduced will ensure that the PIC will select two Care Plans each week chosen at random to be analysed and reviewed with the nurse on duty at the time.

The PIC has commenced an additional referral programme. Specific residents the subject of an immediate action plan have been referred since the inspection as per the response to the immediate action requirement. All residents will be assessed regularly in relation to being referred to any relevant specialist. To date 11 referrals have been made in respect of 9 residents.

All care plan documentation will be made centre specific, this exercise will be completed by November 30th.

The PIC in conjunction with nursing staff will review and assess records and the use of records regarding pain management. A more deliberate notation will be developed to ensure there is cohesiveness across all documentation. To be completed by November 30th.

The statement of purpose document has been amended where necessary. COMPLETED

The directory of residents has been updated. COMPLETED

Notifications required will be forwarded by Wednesday 12th November

The Provider is purchasing a new PC based system. This will be fully functional with comprehensive documentation by January 31st.

It is intended that this system will facilitate the updating of policies and help to eliminate handwritten amendments.

The General Manager and Provider Director are currently reviewing the Risk Management policy to ensure it is compliance with the relevant regulations and standards. This review and updating will be completed by November 30th.

The PIC has introduced a new policy on self harm dated 14th October and staff have

been made aware of same. COMPLETED

**Proposed Timescale:** 31/12/2014

**Theme:**

Governance, Leadership and Management

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

The directory of residents was missing some items of required information. Not all notifications under regulation 31 of the legislation were forwarded to the Chief Inspector.

**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 PIC has updated the Directory of Residents to record the specific missing piece of information. COMPLETED

The amended notifications regarding absconsion will be forwarded by 15th November.

**Proposed Timescale:** 15/11/2014

**Theme:**

Governance, Leadership and Management

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

Daily care plan progress notes were not linked to care plans and as such were not informative regarding effectiveness of care plan interventions. Residents' progress notes did not include information that evaluated level of individual participation or whether the activities provided resulted in positive outcomes for residents. Residents' care plan documentation was not centre-specific.

Records were not maintained in relation to some residents' pain management.

**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:**

The PIC and General Manager are reviewing the records required by schedules 2,3,4 with a view to ensuring that all required records are maintained in the centre, to identify any gaps in those records currently maintained and to update and amend records as necessary.

The PIC will review how better to link Daily care plan notes to individual care plans. The Provider is purchasing a new PC based record and care management system which will assist in ensuring that there is no gap between Care Plans and Daily Progress Notes. The review by the PIC will be completed by the 30th November. The pc based system will be fully functional by the 31st January.

The PIC and Activities coordinator will jointly develop a new system or procedure to update activities involvement and ensure same can be added by nurses to daily care notes and subsequently reflect in Care Plans so that amendments may be made as required. This process will be completed by 30th December.

The Provider will develop new Care Plan documentation to ensure it is centre specific. This process will be completed by November 30th.

The PIC and nursing staff will ensure that the pain management notes of any resident which are not up to date or comprehensive will be updated. This will be completed by November 30th.

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**Proposed Timescale:** 31/01/2015

**Theme:**

Governance, Leadership and Management

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

The statement of purpose document available in the centre was not accurate.

Records regarding fire evacuation drills and staff training were incomplete.

The duty rosters given to the inspectors did not reference the times the person in charge was on duty in the centre and as the deputy person in charge was found to be no longer working in the centre, details of deputising arrangements when the person in charge was not in the centre were not indicated. All persons working at the centre on the day of inspection was not included on the roster provided.

**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:**

Note:- the duty rosters do include details of the hours worked by the PIC.

The PIC and General Manager are reviewing the records required by schedules 2,3,4 with a view to ensuring that all required records are maintained in the centre, to identify any gaps in those records currently maintained and to update and amend records as necessary. Completed by November 30th

The Provider has revised the Statement of Purpose document to reflect the current

situation (prior to registration of new building). Completed

The General Manger maintains comprehensive fire training records in the Centre but will review same in respect of format and layout. Completed by 30th November

The Provider is in the process of ensuring the appropriate arrangements regarding deputising have been made. Completed by 15th November.

**Proposed Timescale:** 30/11/2014

### **Outcome 06: Absence of the Person in charge**

**Theme:**

Governance, Leadership and Management

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

A notification was not forwarded to the Chief Inspector to reference change of deputy person in charge/person participating in management.

**Action Required:**

Under Regulation 33(2)(c) you are required to: Give notice in writing to the Chief Inspector of the name, contact details and qualifications of the person who will be or was responsible for the designated centre during the absence of the person in charge.

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

The existing Deputy Person in Charge departed suddenly following her husband's death, as is legally required the position was held open until such time as she formally resigned which didn't take place for some months.

The Provider will address the issue of Notification of a deputy person in charge. This will be completed by 15th November 2014.

**Proposed Timescale:** 15/11/2014

### **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:**

Restraint use was found to be not in line with best practice in terms of release schedules, consultative procedures and adequate risk assessment and appropriateness of use of chairs with fixed tables fitted as restraints.

**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 Provider has replaced two buxton type chairs. Release schedules are in place and observed.

One resident insists on continuing to use her current chair despite the fact that the nursing home has provided a new and different chair.

If any form of restraint is to be used in the Centre the PIC will liaise with relatives, next of kin, GP and other specialists as necessary and will develop appropriate individual release schedules for each proposed use of any restraint.

**Proposed Timescale:** 24/12/2014

**Theme:**

Safe care and support

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

Some staff were unaware of the elder abuse referral procedures outside of the nursing home if 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 PIC will conduct further training with staff at staff meeting to brief on elder abuse policy with particular reference to elder abuse reporting procedures outside the nursing home.

The PIC has prepared a briefing document for staff to ensure all staff are fully aware of elderly abuse reporting procedures. Completed

The PIC has updated the Policy on elder abuse with specific details of the local Senior Case Worker. Completed

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

Not all staff files reviewed were in compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. There was confirmation of An Garda Síochána vetting missing for one staff member.

**Action Required:**

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

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

The General Manager has obtained Garda vetting which was missing for one staff member.

**Proposed Timescale:** 24/12/2014

**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:**

Not all hazards throughout the centre were identified and risk assessed and those hazards identified did not detail comprehensive measures and actions to control risks.

**Action Required:**

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

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

The General Manager and Provider Director are currently undertaking a review of all risk hazards in the centre with a view to identifying and documenting any previously unidentified risks. This exercise will be completed by 30th November.

The General Manager and Provider Director will rewrite the Risk Management policy and associated procedures to ensure they comply fully with the specific requirements of Schedule 5.

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

The risk of self-harm was not identified.

**Action Required:**

Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

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

The General Manager and Provider Director will ensure that the risk of self harm will be included in the revised risk management documentation and policy to ensure compliance with Schedule 5 requirements.

The PIC has compiled a new policy on self harm and will promulgate same to all staff.

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

The risk management policy did not reference arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Action Required:**

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

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

The General Manager and Provider Director are reviewing and amending the Risk Management policy to ensure that arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents will be included in the revised risk management documentation and policy to ensure compliance with Schedule 5 requirements.

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

An unlocked wooden shed was accessible to vulnerable residents; the contents included hazardous chemicals including weed-killer.

The designated smoking area was not closed off from the rest of the centre. A resident was observed smoking and was not adequately supervised by staff. There was also a risk posed to other residents and staff of secondary smoke inhalation which was not assessed.

The information in relation to health and safety arrangements in the centre described within the safety statement was not comprehensive.

**Action Required:**

Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy

set out in Schedule 5 includes the measures and actions in place to control the risks identified.

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

The General Manager and Provider Director are currently reviewing the Risk management policy to ensure all identifiable risks are identified and to include the measures and actions in place to control the risk identified. This will be completed by December 30th.

The General Manager will ensure the use of the wooden shed is discontinued on the use of the new building. In the interim he will ensure a new lock has been placed on same. COMPLETED

The PIC has developed new procedures regarding monitoring the sole resident who smokes. This will ensure all staff on duty are aware of the fact that the resident has requested to smoke and at what time. Staff will then be required to undertake monitoring on the individual resident.

The General Manager will assess the issue of secondary smoke inhalation and include same in the rewritten hazard identification and risk management policy.

The General Manager has inserted a new powerful extractor fan in the current smoking area to eliminate any smoke.

The new building will have a dedicated smoking room.

The General Manager will amend and update the Safety Statement as required.

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

There was evidence of procedures and practices in the centre that were not consistent with standards for the prevention and control of healthcare associated infections published by the Authority.

**Action Required:**

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

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

The PIC is researching new training for Staff in infection control procedures. Staff will receive additional updated training in infection control procedures

The PIC will review existing procedures to update same where necessary.

In relation to soiled or infected linen a new system of red and green bags are used to separate and put soiled or infected linen in for washing which alleviates the need to sluice.

A new Infection Control committee has been established which consists of a Nurse, Care assistant and Cook. This Committee will assist the PIC in ensuring that infection control procedures are constantly monitored.

**Proposed Timescale:** 30/12/2014

**Theme:**

Safe care and support

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

Fire safety arrangements in the centre were not of an adequate standard to ensure that residents could be safely evacuated to a place of safety in the event of a fire in the centre.

**Action Required:**

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

A consultant fire engineer has undertaken a review of the existing centre.

His report has been sent to the Authority.

All the recommendations of his report have been implemented.

All fire fighting equipment has been re-tested.

All fire signage had been tested and is working order.

Additional fire signage has been introduced.

8 new fire marshals have received training from specialised firm.

Standard fire training for staff has been completed by an independent firm.

Additional items required by the Fire Officer have also been implemented.

The General Manager will review the fire training records and revise the layout of same

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

While staff training in fire safety and evacuation was done. Some staff spoken with did not have a basic knowledge of the evacuation arrangements in the centre.

**Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency

procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Eight new fire marshals have been trained

Additional fire training for staff has been completed by an independent firm.

The General Manager has instituted a new procedure whereby staff are randomly tested weekly on their fire training knowledge to ensure all staff will have knowledge of relevant evacuation routes and fire safety training.

The General Manager will introduce additional signage to relevant areas of the Centre to be located on the advice of the Fire Engineer and generally.

The General Manager will review and amend as necessary all relevant documentation.

The General Manager has added a number of new fire blankets at relevant points in the Centre.

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

Although documentation referenced a fire drill having taken place on 2 July 2014 that addressed day and night evacuation procedure, there was no evidence that staffing levels at night were adequate to meet the evacuation needs of residents including residents who remained in bed or had behaviour that challenged.

**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 General Manager has arranged additional fire training which focused on how to manage residents who are bedbound or are challenging in their behaviour or whose clothes have caught fire. This training will be completed Friday 31st October.,

The PIC and General Manager have developed Personal Evacuation Plans for all existing 21 residents.

The General Manager has placed Personal Evacuation Plans for each resident in their room.

The PIC has made all staff aware of new Personal Evacuation Plans

The General Manager has ensured additional fire evacuation drills have been and continue to be conducted with particular emphasis on evacuation procedures.

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

The safety statement referenced the centre as being divided into five fire zones, however no reference was made to this arrangement in the fire evacuation plan. The fire evacuation plan or procedures to follow in the event of fire was not adequately displayed.

**Action Required:**

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

The General Manager will review and updated the existing procedures which are displayed to include appropriate reference to relevant zones.

The General Manager will review The Safety Statement and amend as necessary to ensure same is appropriate.

**Proposed Timescale:** 30/11/2014

**Outcome 09: Medication Management**

**Theme:**

Safe care and support

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

Documentation and consent forms made available to the inspectors did not confirm that all residents were given a choice of pharmacist.

**Action Required:**

Under Regulation 29(1) you are required to: Make available to the resident a pharmacist of the resident's choice or who is acceptable to the resident.

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

The PIC has discussed the issue of pharmacists with all relevant residents and explained the availability of choice regarding pharmacists to same.

Any residents without a consent form who can have been asked to provide consent to use of pharmacist..

The PIC will discuss the issue of consent forms with relatives and next of kin and completed consent forms will be obtained from next of kin at earliest opportunity where they are currently not completed.

**Proposed Timescale:** 30/12/2014

**Theme:**

Safe care and support

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

The service level agreement did not describe the provision of pharmaceutical care to residents by the pharmacist in line with guidance issued by the Pharmaceutical Society of Ireland.

**Action Required:**

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

The PIC has held discussions with the Pharmacist and he has completed a new service level agreement and consent form to ensure it is in compliance with guidance issued by PSI.

The pharmacist has also provided signage for use in the nursing home that he is available for consultations.

**Proposed Timescale:** 30/11/2014

**Theme:**

Safe care and support

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

Expiry dates were not available for short-term medications dispensed out of their original packaging and staff could not identify when these medications were due to expire.

**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:**

All nurses have signed a document stating that they will not accept medications from a pharmacy which does not have an expiry date.

The PIC met with the Pharmacist and has discussed and reiterated to the Pharmacist that no medication can be accepted without an expiry date on same.

The PIC has reiterated to staff not to use any medication without an expiry date and to return same to pharmacy.

The PIC has updated the Medication management policy.

**Proposed Timescale:** 24/12/2014

**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:**

A notification of a serious injury to a resident was notified to the Chief inspector as a quarterly notification and as the resident concerned sustained a fall and required transfer to hospital for review, a notification of serious injury is required.

A notification referencing an incident where two vulnerable residents left the centre unaccompanied requires revision to document this incident for each resident individually and notify the Chief Inspector accordingly.

**Action Required:**

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

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

The PIC will provide amended and appropriate notifications.

**Proposed Timescale:** 15/11/2014

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

**Theme:**

Effective care and support

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

Inspectors found from the care plans reviewed that not all residents' needs identified had an associated care plan in place to inform required care interventions.

**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 PIC has instituted a review of all residents care plans. Any need of a resident which is not being met will be identified. Any unmet identified need will be reviewed and an appropriate action taken to address same.

All care plan documentation has been revised to remove any generic material / statements and replaced with nursing home and resident specific information.

**Proposed Timescale:** 30/11/2014

**Theme:**

Effective care and support

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

Access to behavioural support services, physiotherapy, occupational therapy and speech and language therapy specialist services was not adequate.

Pain assessment tools were not routinely used for managing residents' pain in line with evidence-based practice.

**Action Required:**

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

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

The PIC in conjunction with nursing staff has begun a programme of identifying specialist services required by residents as part of the review of care plans.

The PIC has developed a programme of referrals to specialist services for residents where appropriate. 11 Referrals have been made recently to a range of specialist service providers. Ongoing

The PIC in conjunction with nursing staff is reviewing the use of Pain Assessment tools.

**Proposed Timescale:** 30/11/2014

**Theme:**

Effective care and support

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

Not all transactions were included in the controlled drugs register in line with the Misuse of Drugs Act 1988.

**Action Required:**

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

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

Staff have been instructed again as to their responsibilities in relation to the Misuse of Drugs Act and a new spot check will be undertaken on the register by the Person In Charge on a weekly basis.

**Proposed Timescale:** 24/12/2014

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

The design and layout of some parts of the building do not meet their stated purpose due to;

- Laundry is an inner room in the sluice, it is not adequately ventilated and lacks adequate space for segregation of soiled and clean linen, does not have an ironing facility and was not fit for the purpose of laundering residents' clothing.
- Smoking area was not closed off from the rest of the centre and exposed residents, staff and visitors to secondary smoke risks.
- Glass panels in the adjoining wall of a corridor and bedrooms numbered 15, 16 and 17 did not ensure the privacy of the residents residing in these rooms.
- Glass panel in wall between a corridor and a communal shower/toilet did not ensure the privacy of residents using this facility was respected.
- No cleaner's room
- suitable changing and storage facilities for staff were not available.

The inspectors were informed by the provider that provisions have been made for the all of the aforementioned non compliances in the new build and will be inspected by the Authority on notification that the new build is fully completed and ready for occupation by residents.

**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:**

As noted a new building is just completed and will address the items listed.

In the interim the General Manager will undertake the following measures

- 1)the glass panels overlooking the corridors have been shielded further.
- 2)The obscure glass panel into the shower room has been curtained to block it fully.
- 3)A new extractor fan has been introduced into the smoking area to eliminate smoke fumes.
- 4)An interim cleaners room for storage will be made available.

**Proposed Timescale:** 30/11/2014

**Theme:**

Effective care and support

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

The design and layout of some parts of the building do not meet their stated purpose due to;

- No external windows were fitted in rooms 15 and 16.
- Windows boarded up in one residents' bedroom numbered 11 and en-suites boarded up in rooms numbered 11, 15 and 16 resulting in no natural light or ventilation.
- single bedroom on the 2nd floor, accessible by three steps did not have lift access.
- Floor covering in room 12 was severely damaged and not of a standard to facilitate adequate cleaning.
- Sluice area is not fit for purpose and does not meet the minimum requirements as stated in the standards.
- Residents do not have access to a garden. An inner courtyard for use by residents had unsafe surfaces, an oil tank which the provider said was no longer used, an unlocked wooden shed containing hazardous chemicals including weed killer and was an access area to the kitchen and sluice.
- En-suite facilities blocked by commodes for example a commode was stored in the en-suite in bedrooms 11 and 16.
- Lack of storage for residents' equipment including hoists, wheelchairs stored on a corridor and commodes stored in bedrooms while the residents in those bedrooms were using communal facilities.
- There was evidence of damp on the ceiling of a twin bedded room occupied by residents.
- Access to a hand hygiene sink was obstructed by a television placed in front of it in a twin bedded room.
- There were no pedestrian footpaths in place along the entrance roadway or around the front of the building.
- Car parking provided was immediately in front of the building and was limited to two to three cars necessitating car manoeuvring in close proximity to the front door. However, inspectors were told that this restriction was a temporary arrangement to facilitate building works.
- Adequate communal accommodation was not provided for residents.

The inspectors were informed by the provider that provisions have been made for the all of the aforementioned non-compliances in the new build and will be inspected by the Authority on notification that the new build is fully completed and ready for occupation by residents.

**Action Required:**

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

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

As noted a new building is almost completed and will address these issues.

The General Manager has added a velux window to room 11 and daylight is evident now in the room.

**Proposed Timescale:** 24/12/2014

**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:**

Inspectors found that an appeals process was not adequately documented.

**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:**

The PIC has reviewed the appeals process and same has been revised and updated.

**Proposed Timescale:** 24/12/2014

**Theme:**

Person-centred care and support

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

The satisfaction of the complainant with the outcome of investigation was not consistently documented in each case or information on an appeals process was not communicated to the complainant.

**Action Required:**

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

The PIC has reviewed the information required under Regulation 34 (1) (f) and will ensure that same is amended and updated as required to ensure it is in compliance

with the Regulation with particular reference to the consistency of same.

As part of the process of review the PIC will ensure the procedures are amended to provide for details of any investigation, the outcome of any complaint and whether or not the resident was satisfied.

**Proposed Timescale:** 30/12/2014

### **Outcome 15: Food and Nutrition**

**Theme:**

Person-centred care and support

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

Inspectors observed that while adequate fluids were provided, a water cooler dispenser was located in an area outside the inner front door and as such was not accessible to residents.

**Action Required:**

Under Regulation 18(1)(a) you are required to: Provide each resident with access to a safe supply of fresh drinking water at all times.

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

Residents are supplied with all the drink and sustenance they require at any time by staff and have jugs of fresh water in their rooms and visit the kitchen if they like.

The water cooler is intended for relatives use only and has been moved inside the door.

**Proposed Timescale:** 24/12/2014

**Theme:**

Person-centred care and support

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

The inspector observed that residents were served modified consistency meals on assessment by staff without evidence of choice and not supported by referral and assessment by speech and language therapy expertise to ensure the level of modification was adequate or appropriate.

**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 PIC has arranged for an assessment to be conducted by a Speech and Language

therapist which has confirmed that all relevant residents were already receiving appropriate consistency food.

The PIC will arrange for an assessment to be obtained if required from a Speech and Language therapist in future and documented in residents care plans.

**Proposed Timescale:** 24/12/2014

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

### **Theme:**

Person-centred care and support

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

Residents' privacy and dignity needs were not adequately met due to

- screen curtains reviewed were not of a quality to fully obstruct view and preserve privacy when closed.
- panel windows in an adjoining wall with a corridor between three bedroom walls and a communal shower/toilet permitted view of the residents within these facilities.
- Commodes were stored in a number of residents' bedrooms during the days of inspection while the residents residing in the bedrooms used communal facilities in the centre. The impact on the dignity of residents concerned had not been considered or assessed.
- the procedures in place for managing one resident with challenging behaviour that impacted negatively on his elimination activities did not ensure that all aspects of his dignity needs were respected.

### **Action Required:**

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

As noted the new building which is complete will address these issues.

In the interim additional screening has been added to curtains where necessary.

Panel windows overlooking a corridor have been further shielded with curtains.

Commodes have been removed

The procedures are currently being reviewed by the PIC in conjunction with the resident's GP. Further specialist advice has been sought on these procedures. A behavioural plan is in place with clear reactive and proactive strategies in place.

The resident is currently fully facilitated to undertake such activities in private as per the regulations and the issue is not one of privacy but an acceptable process of elimination of waste faecal matter by the resident.

The issues of infection control and prevention and waste removal are being investigated to determine how changed or enhanced procedures could address these issues further.

A new procedure whereby faeces is bagged and then bagged again in a yellow bag and a tag placed on it by the carer has been adopted. This ensures that the bag containing the faeces is not touched again before leaving the room.

In addition the PIC is researching other forms of receptacle which might add to the residents dignity.

The PIC will look continuously for new procedures which will improve the situation and will implement same if suitable to resident.

**Proposed Timescale:** 24/12/2014

**Theme:**

Person-centred care and support

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

Residents' care documentation and observations by inspectors found that there was poor evidence of provision of a meaningful programme to meet their social care needs.

**Action Required:**

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

The PIC and Activities Coordinator will review the evidential requirements in relation to social activities. An upgraded personal plan with detailed level of involvement would be utilised in future.

The PIC and Activities Coordinator will also examine the current programme to develop additional/different opportunities for residents where appropriate and which they are willing to participate in.

**Proposed Timescale:** 30/11/2014

**Theme:**

Person-centred care and support

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

No designated visitor's room or second sitting area to enable residents to meet their visitors in private outside their bedroom was provided.

**Action Required:**

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the

resident's room, if required.

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

Visitors are facilitated to meet with relatives in private through use of the existing dining room which complies with the regulatory requirement.

The new building will have a dedicated meeting room.

**Proposed Timescale:** 24/12/2014

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

There was evidence to support the finding that staffing levels were not adequate to meet the needs of residents with regard to adequate supervision to mitigate risk of resident incidents, to evacuate residents at night-time if required and to complete cleaning at weekends.

**Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

The Provider has engaged an additional staff member to work at night time pro tem a move to a new building. This staff member has already commenced work.

The General Manager has engaged an additional cleaner to undertake cleaning duties at weekend. This staff member commences work on Friday 7th November.

**Proposed Timescale:** 24/12/2014

**Theme:**

Workforce

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

There was evidence that staff had not completed mandatory training as required in fire safety and protection of vulnerable adults. Training records were not readily accessible.

**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 General Manager and PIC will review training schedules to ensure that all staff will complete any mandatory training which is not completed.

The General Manager will review the accessibility of files and look for opportunities to improve the accessibility to same.

**Proposed Timescale:** 30/12/2014

**Theme:**  
Workforce

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

There was no evidence of adequate arrangements for supervision of a staff member who worked on continuous night duty.

**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 PIC will review the existing arrangements in place for supervision of staff working at night to identify any aspects which can be changed / added.

The PIC will supervise the completion of a medications round by night nurses. This has been done on two occasions. COMPLETED

The PIC will institute an additional programme of documenting supervisory proceedings with night staff to add additional evidentiary records of same to existing records.

**Proposed Timescale:** 30/11/2014