<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Clonskeagh Community Nursing Unit</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000491</td>
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<tr>
<td>Centre address:</td>
<td>Clonskeagh Road, Dublin 6.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 268 0300</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:mary.nally@hse.ie">mary.nally@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>John O'Donovan</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Mary Nally</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Deirdre Byrne</td>
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<tr>
<td>Support inspector(s):</td>
<td>Linda Moore</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>85</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>6</td>
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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.
The inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 07 May 2014 08:00
To: 07 May 2014 18:00
08 May 2014 08:00
08 May 2014 19:30

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

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<th>Outcome 02: Contract for the Provision of Services</th>
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<td>Outcome 05: Absence of the person in charge</td>
<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents clothing and personal property and possessions</td>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This announced monitoring inspection was carried out over two days and specifically to inform a decision to register the centre under a new provider. As part of the inspection, inspectors observed practices and reviewed documentation such as care plans, accident logs, policies and procedures.

The provider had applied to the Chief Inspector, to renew registration of the centre and an inspection to inform the decision took place on the 14 and 15 January 2014. At that inspection, inspectors had significant concerns with the overall management of the centre and the fitness of the person in charge. The provider was required to attend meetings on two occasions in March and April 2014 with the Health
Information and Quality Authority (the Authority) Regulation Directorate to discuss the significant non-compliances with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). The provider assured the Authority an improvement plan was underway to mitigate the issues identified, and a written account of the plan was submitted. This announced inspection was carried out to monitor the centre and to assess ongoing compliance with the Regulations.

Overall inspectors found that improvements were required in a number of areas in order to bring about substantial compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

While progress had been made to address some issues raised at the previous inspection, inspectors had concerns regarding the participation of the person in charge in the clinical governance of the centre. Issues identified at all previous inspections such as the notification of incidents to the Chief Inspectors and the care planning process continued to be in breach of the Regulations. The supervision of staff and the mealtime experience for residents was of particular concern for inspectors at this inspection. Furthermore practices in place to ensure residents were provided with choice and dignity required improvement. Other clinical areas including the management of residents nutritional needs and the management of restraint also required improvement.

The physical environment did not meet the needs of all residents with regard to the decor, communal areas, storage space and multi-occupancy bedrooms. The notification of incidents to the Authority required improvement as the person in charge had failed to notify the Authority of allegations of staff misconduct.

Inspectors found evidence of improved practices in relation to medication management and falls management. Improvements had taken place with regard to the level of staffing and the management of complaints.

Questionnaires returned by residents and relatives expressed a good level of satisfaction overall with the service provided, it was noted that comments raised included issues around activities and the variety of food available.

These issues are further discussed in the body of the report and in the Action Plan at the end of the report.
**Section 41(1)(c) of the Health Act 2007 Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

**Outcome 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:**
Leadership, Governance and Management

**Judgement:**
Non Compliant - Minor

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

**Findings:**
The statement of purpose which was in place did not fully meet the requirements of the Regulations.

Inspectors read the statement of purpose which had been recently revised, however improvements were identified. For example, it did not accurately reflect the management structure. Other required details such as how to make a complaint, the fire evacuation procedures and the size of rooms were not adequately described.

Inspectors found that care was not consistently delivered in line with the aims and objectives set out in the statement of purpose. For example, the provision of opportunities for meaningful social engagement was not provided based on all residents’ assessed needs and interests as described in the statement of purpose. This is further discussed under outcome 11. This had been an action at the previous inspection and was not completed.

**Outcome 02: Contract for the Provision of Services**

*Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.*

**Theme:**
Leadership, Governance and Management

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

Findings:
Inspectors were satisfied a contact for the provision of service was in place for each resident.

Since the previous inspection, improvements had been made to residents' contract of care. Inspectors were shown a copy of a new contract, it now included details of the services provided and the fees to be charged to residents. The contract was being rolled out to new residents and re-issued to all current residents. It was proposed to include an appendix of services that would incur an additional fee.

Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Judgement:
Non Compliant - Moderate

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

Findings:
While the requirements for the role of person in charge were met, with regard to qualifications and experience, inspectors had a number of concerns regarding this outcome.

The person in charge was a registered general nurse, had the relevant necessary experience and worked full-time in the centre. However, inspectors observed a number of issues in relation to clinical governance and supervision which included nutrition management, continence promotion and restraint management. These issues are discussed further under outcome 11. Inspectors also had concerns regarding the mealtime experience, furthermore, inspectors were concerned at the lack of leadership and action taken by the person in charge in response to these concerns when raised by inspectors as discussed further under Outcome 15. Additionally, catering staff did not have an up-to-date record of residents' dietary needs and preferences and inspectors were concerned that this could result in poor outcomes for residents.

Inspectors were also concerned that issues raised at the previous inspection such as care planning and the implementation of an effective system of audits, as outlined under outcomes 10 and 11, had not been adequately addressed by the person in charge.
Inspectors found staffing issues in relation to the supervision of residents as discussed in Outcome 18. There were poor practices observed around residents in her care in relation to privacy, dignity and respect as outlined under Outcome 16.

Inspectors also found that there was unsatisfactory management of risk by the person in charge and a failure to show leadership and implement improvements in response to incidents occurring in the centre.

The person in charge had been in post since 2006. A Fit Person interview was held with the person in charge during which she demonstrated knowledge in relation to a number of clinical areas and her responsibilities under the Regulations. Inspectors found that she had participated in continued professional development. She was in the process of completing a certificate in leadership management. The person in charge stated that she maintained her professional development attending in house clinical courses. Inspectors saw documentary evidence that she had attended mandatory training in fire safety, manual handling and the protection of vulnerable adults.

Inspectors were satisfied that there were satisfactory deputising arrangements in place as provided by two assistant directors of nursing (ADON). Both of these individuals participated fully in the inspection process and both demonstrated good clinical knowledge and a satisfactory understanding of their roles and responsibilities under the Regulations although some knowledge deficit was noted in the area of notifications to the Chief Inspector.

The person in charge was supported in her role by the provider and met with him formally on a monthly basis to discuss management issues. She was also supported by administrative staff who worked full-time in the centre and were responsible for managing non-clinical aspects of the service.

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

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Theme:**

Leadership, Governance and Management

**Judgement:**

Non Compliant - Minor

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

Some action(s) required from the previous inspection were not satisfactorily implemented.
**Findings:**
Inspectors found improvements were identified in the systems to maintain complete records and the required policies in place.

The action from the previous inspection which related to the development of written operational policies was not fully addressed. For example, the risk management policy and protection of vulnerable persons policy were not comprehensive enough to provide direction. These matters are discussed under outcomes 6 and 7. The falls and complaints policies had been revised since the last inspection and provided clear guidance for staff. Staff members were sufficiently knowledgeable regarding these operational policies.

An insurance policy was read, and it was noted reference was also made to the policy in the residents contract of care. However, it did not fully meet the requirements of the regulations. For example, residents personal effects were not covered to up to €1,000 per item.

Inspectors found that medical records and other records, relating to residents and staff, were now maintained in a secure manner which addressed an action from the previous inspection.

Inspectors also reviewed the directory of residents and found that it had been revised and updated in response to the previous inspection. It now contained all the required documentation. There was a new Residents Guide seen by inspectors, and it now included a copy of the recent inspection report and contract of care.

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**Outcome 05: 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:**
Leadership, Governance and Management

**Judgement:**
Compliant

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

**Findings:**
Inspectors were satisfied the provider had adequate arrangements in place should the person in charge take leave requiring notification to the Chief Inspector.

There were formal measures in place in the event of any such absence. Two ADONs deputised for the person in charge in her absence.
### Outcome 06: Safeguarding and Safety

*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.*

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Major

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

**Findings:**
Inspectors were concerned that routines and practices in the centre did not maximise each resident’s independence and choice, and resulted in potential neglect of their needs. On a number of occasions throughout the inspection, the inspectors observed that requests from residents were not responded to or carried out by staff. For example, on the morning of the first day of the inspection, inspectors sat with residents in a small dining area of one unit. Three residents in wheelchairs called for assistance while the inspectors sat with them. One resident was calling to go to the toilet. There was no call bell placed close by any of these residents to call for assistance. Residents told inspectors there was not enough staff in the morning and they would be left waiting after breakfast to be brought back to their room. A nurse informed inspectors six staff were on duty that morning, but three had gone on break. After more than five minutes passed a nurse entered the room. The nurse did not ask the residents what their wishes were or why they were calling. The resident who needed to be brought to the toilet was then brought to another sitting area, and left alone. Inspectors observed the resident continued to call for assistance. At this point inspectors intervened and requested assistance for the resident to be brought to the toilet. Inspectors were so concerned in relation to this matter that it was brought to the attention of the person in charge. However, it was not appropriately responded to as there continued to be incidents of residents calls not being responded to throughout the remainder of the inspection which are outlined in outcomes 15 and 16.

Inspectors followed up on the actions from the previous inspection, and they had been addressed. The person in charge was now very clear of the arrangements to respond and investigate any reports of alleged or suspected abuse made to her. She clearly described the procedures to be put in place to protect residents and carry out an investigation. This had been an area of improvement at the previous inspection and was now resolved.

There was a policy on the protection of vulnerable adults which had been recently revised. However, further improvement was identified to guide staff practice. For example, it did not include the details of referral to residents next of kin or the general practitioner. The nominated provider also demonstrated knowledge and understanding.
of this policy and outlined the appropriate steps to take in the event that any allegation of abuse was made.

Whilst residents reported they felt safe, during the inspection, an allegation of abuse was made to the inspectors. This was reported to the person in charge. Although she informed inspectors she was aware of the requirement to notify it to the Chief Inspector, inspectors had identified incidents during the inspection involving residents that had not been notified. This had been a persistent issue at previous inspections and is further discussed under outcome 9. The allegation was notified to the Chief Inspector following the inspection.

The training records showed that staff had received regular training on how to respond to any allegation of abuse. Inspectors found that staff on duty on the day of inspection were knowledgeable with regard to their responsibilities in this area.

Inspectors reviewed the systems in place for safeguarding residents’ money and found evidence of good practice. Improvements had been identified at the previous inspection and were addressed. A robust system of documentation was in place to monitor and record all transactions which were accompanied by two signatures.

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### Outcome 07: Health and Safety and Risk Management

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

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
While some systems were in place to promote the health and safety of residents, staff and visitors a number of improvements were required.

Inspectors found that the systems in place to manage risk were not robust. A risk management policy that had been recently revised was read by inspectors. However, improvements were identified as it did not fully meet the requirements of the Regulations and was not comprehensive enough to provide direction to staff. For example, there was no reference to the arrangements in place investigate and learn from accidents and incidents in the centre. This had also been an area of improvement at the last two inspections and was still not addressed. A health and safety committee met every three months the last meeting had been in October 2013. Although inspectors saw minutes of meetings, there was no evidence that these had been shared or discussed with staff. The next meeting was planned for May 2014. There was an up-to-
Inspectors saw that a member of the nursing staff was responsible for carrying out risk assessments and provided support to other nurses on an on-going basis. For example, recent risk assessments had been carried with regard to clinical risk of residents. However, while the staff had previously attended training, no other staff had been provided with training in risk assessment and some of the risk assessments, which had been carried out, were not fully completed and some did not clearly identify the interventions which were necessary to manage identified risks. For example, residents at risk of choking, at risk of abscondion and risk of smoking.

A number of risks associated with the service had also not been risk assessed for example, the smoking room. This was discussed with the nurse who undertook to complete a risk assessment of the room on day 2 of the inspection.

As outlined above, the policy did not include the arrangements for investigation and learning from serious incident events involving residents. There was an efficient system in place for the recording of accidents, incidents and near misses. This information was reviewed by the ADONs and all incidents were submitted to the provider for further review. However, there was no effective system for investigating and learning.

There was an emergency plan in place. However, it was not comprehensive enough to direct staff. For example, it was limited to fire evacuation procedures. The person in charge informed inspectors she had recently attended a study day and would be revising the emergency plan to include other types of incidents. This had been an action at the previous inspection and was not addressed.

The training matrix showed that staff had up-to-date training in moving and handling. Residents’ moving and handling assessments were routinely assessed and instructions for assisting residents to mobilise were available in the care planning documentation which was readily accessible to the appropriate staff.

Inspectors found fire safety procedures and associated records were adequate. A number of areas of improvement identified at the previous inspection had been addressed. Fire orders were prominently displayed, fire exits were unobstructed and staff members, spoken to by inspectors were knowledgeable with regard to the procedures to follow in the event of fire. Records read by inspectors confirmed that fire drills were taking place on a weekly basis at weekends. However, there was no record of the length of time and the outcome from each drill. The training records showed that staff had up-to-date training in this area. Inspectors also reviewed the records with regard to servicing of equipment. The records showed that there was regular servicing by external consultants of the fire detection and alarm system and of fire fighting equipment. Although a documented system of daily in-house checks, these were of the fire extinguishers only, and fire exits checks were not included.
**Outcome 08: Medication Management**

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

**Theme:**
Safe Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Inspectors found that policies and procedures were in place for the safe management of medications. The issues identified at the previous inspection had been addressed. There was a centre specific policy medication policy in place. However, the medication policy was not adhered to in practice.

Inspectors reviewed the prescription and medication administration records for a sample of residents. However, improvement was identified. For example, one resident was administered a medication without a prescribed day or time. Inspectors also observed one resident's medications had been left on a dining room table and had not yet been taken. These were not in accordance with the centres policies and professional guidelines.

Although nursing administration outlined to inspectors a new auditing process due to be carried out by the pharmacy service, it had not yet been implemented. Therefore, there was no effective system auditing to identify areas of improvement in medication practices, including those outlined above.

All of the nursing staff had been provided with training in medication management. Inspectors saw medications were stored appropriately. Medication errors were appropriately managed. Written evidence was available which showed that three-monthly reviews of residents’ medications were carried out by the GP.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines and the centre’s policy. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the time of administration and change of each shift. Inspectors checked the balances and found them to be correct.
**Outcome 09: 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

**Judgement:**
Non Compliant - Major

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

**Findings:**
Inspectors found a record of all incidents occurring in the centre was maintained however, a number of incidents had not been notified to the Chief Inspector where required.

Inspectors reviewed the complaints log, and found a number of incidents of alleged staff misconduct had not been notified to the Chief Inspector as required. This had been an area of non-compliance at all previous inspections. This was discussed with the person in charge, who was not aware with of the requirement to notify these particular incidents. Following the inspection, notifications for the incidents were submitted to the Chief Inspector.

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**Outcome 10: Reviewing and improving the quality and safety of care**
*The quality of care and experience of the residents are monitored and developed on an ongoing basis.*

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
Inspectors found there were systems in place to monitor and review the safety and quality of care of residents in the centre, however they were not sufficiently robust to effect change and drive improvement. This had been an action identified at the previous inspection and was not fully addressed at this inspection.
Since the last inspection, the person in charge had commenced the review of a number of key performance indicators (KPI) and inspectors saw audits had been carried out on areas including restraint, infection control and falls. Good practice was evident in relation to analysis for these KPIs. For example, pertinent data on infections indicated a high number of residents experienced urinary tract infections and respiratory tract infections, similarly with restraint, a very high level of bed rail and lap belt usage identified. However, there was no action taken in relation to the findings affect change therefore there was no evidence of continued improvements brought about to enhance the overall quality and safety of care.

Inspectors found residents were not consulted with in reviews and audits, and staff were not informed of the findings for learning purposes. Furthermore there was no formal plan in place to review other key performance indicators.

**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. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Moderate

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

**Findings:**
While improvements were made to address some of the issues raised at the previous inspection, there were concerns in relation to the clinical supervision and leadership in the centre. Improvements were required in the area of nutrition, behaviours that challenge, falls, pressure area care and continence promotion. Some issues identified at the previous inspection including care planning and opportunities for social engagement also remained outstanding.

Arrangements to meet residents’ assessed needs were set out in individual care plans based on a range of assessments which had been carried out at routine intervals. Although care plans addressed the identified needs of residents, they did not sufficiently guide the care to be delivered or the interventions in place to direct care. For example, food and nutrition, restraint, behaviours that challenge and end-of-life care. This has been an ongoing area of non compliance as identified at all previous inspections. There
was evidence that the residents and where appropriate the next of kin had been consulted in relation to the development of care plans. Residents health care needs were supported by good access to the G.P. and an out-of-hours service was available. There was evidence resident were seen by a range of allied health professionals, with an in house occupational therapist and physiotherapy service also available.

Inspectors found the management of residents nutritional needs required improvement. Residents were regularly assessed using a mini nutritional assessment (MNA) tool and a care plan was developed where risk was identified. However, improvement was identified. For example, the documentation of MNAs were not completed fully. There was evidence residents were weighted every month and see by a dietician on a monthly basis. Fluid and food charts were put in place for residents at risk of malnutrition or losing weight. However, the charts were not consistently completed. For example, there was no record of one residents food intake for over a week. Where a record was maintained, there was no record other than supplements having been offered to the resident.

Inspectors found the management of behaviours that challenged required improvement. The assessment and identification of behaviours that challenge required improvement. Inspectors found some residents had been incorrectly identified as having behaviours that challenge. For example, staff discussed one residents behaviours as being challenging, such as calling out. When met by the inspectors, this resident did not present with any of these behaviours and had a number of conversations with inspectors during which the resident was clearly able to articulate them self. Where residents had been identified as having behaviours that challenged, monitoring charts were not used to gather information on the triggers to behaviours and to identify effective interventions. Therefore there was no gathering of information to develop care plans. Where care plans were in place, they did not outline the triggers to the behaviours and the strategies to prevent their occurrences. Staff were knowledgeable regarding the needs of residents. Residents who displayed behaviours that challenged were regularly reviewed by the GP and there was good access to the psychiatry of old age team for those residents who required this.

Inspectors found improved practices in the management of falls since the previous inspection, although some improvement was identified. Residents' falls risk was routinely assessed and care plans were developed for residents at risk of falling. Inspectors saw that following a fall a post fall assessment was carried out and a neurological observation was completed. Residents were reviewed by the physiotherapist following a fall. However, an area of improvement was identified. For example, the falls prevention measures recommended by the physiotherapist for one resident who had a recent fall had not been implemented in practice and it placed the resident at risk. This was discussed with the person in charge who undertook to address the matter the day of the inspection. Inspectors were later informed the resident would not be re-assessed till the following day.

Inspectors found evidence of improved practice in relation to the use of restraint. Inspectors saw that a comprehensive restraint assessment was carried out prior to a decision to use restraint. This assessment was carried out in consultation with the resident, the nursing staff and the OT. There was a high use of restraint in the centre
with over fifty percent of residents using bed rails or lap belts. Although the assessment stated that alternatives were considered, there was only five low low beds available in the centre. Therefore the option to choose an alternative to bed rails was not always available or offered to residents.

Inspectors reviewed a sample of care plans for residents who had constipation. However, there evidence the care plans were implemented in practice. For example, high fibre diets and monitoring of fluid intake. Staff described the routine practice of laxative use, however they could not clearly describe the alternatives that they would try prior to the use of laxatives. For example, one resident’s records showed that rectal laxatives were provided to this resident on two consecutive days in May 2014. Staff said that a resident would be administered this medication after 2 to 3 days if required.

Inspectors reviewed practice in relation to pressure area care and found some improvement was necessary. There was routine screening in place in order to identify those residents at a high risk of skin breakdown. While there was a range of pressure relieving equipment in place, pressure reliving mattresses had been set incorrectly for a number of residents and inspectors found that this could present an increased risk to these residents. There was no system in place to routinely check that settings for this equipment. There were no residents with wounds at the time of inspection.

While some residents were seen enjoying group activities during the inspection there was a need for improvement in this area. Most residents who weren't able to or preferred not to go to the group activities, tended to stay in their respective units. However, there was very little planned activity going on in these areas. Residents were observed sitting in their room or the sitting room, with little or no entertainment or activity. Relatives questionnaire reviewed stated some residents found most activities were not suitable and only took place in the afternoon. Some improvement had taken place since the previous inspection, and all residents reviewed had a social care plan in place. There were care plans developed based on a social assessment of residents needs. Records of residents’ participation in social activities were maintained and showed that social care plans were being followed. The activities coordinator and a number of staff had been trained in specialised communication-based activities such as Sonas.

**Outcome 12: Safe and Suitable Premises**
*The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.*

**Theme:**
Effective Care and Support

**Judgement:**
Non Compliant - Moderate
Outstanding requirement(s) from previous inspection:
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors were not satisfied that the design and layout of building fully met the requirements of the Regulations and the Authority's Standards, and the individual and collective needs of the residents. These matters were discussed with the provider and the person in charge who were acutely aware of the deficits with the centre. Inspectors were shown a report which outlined the plans to address the issues along with the multi-occupancy room by 2015. The provider outlined the plans to the inspectors which include a review of the issues by the end of 2014.

The issues are outlined as follows:

- three bedded rooms which do not meet the requirements of the Authority’s Standards.
- the mobile screening provided in the two and three bedded rooms was insufficient to ensure residents privacy.
- the living and dining rooms in each of the centres four units were small in size, and accommodated a maximum of eight to ten residents at any one time.
- the decor of the centre was clinical in nature and required improvement. The decoration was not consistent throughout all units.
- there was inadequate storage space, with hoist and assistive equipment stored in shower and bath rooms.
- there was no provision of a communal toilet for residents close to each of the dining and living areas on each unit.

The centre was in a clean condition, and well maintained to a good standard of repair. A number of residents' bedrooms were seen by inspectors, and most had an en suite shower, wash-hand basin and toilet. All beds had a call bell fitted, and inspectors found these were regularly serviced. Each bedroom was provided with a wardrobe and a locker space with lock. Inspectors visited a number of residents in their rooms and observed they had added their own personal touches to them.

There were a number of secure, enclosed gardens, directly accessible from the centre. They were pleasantly laid out, with paved tiling, and seating areas, along with many potted plants and flowers. An internal, smoking area with mechanical ventilation was located on the ground floor. There was assistive equipment such as hoists and lifts provided, and reports read by inspectors confirmed they had been recently serviced and were in good working order.
**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

**Judgement:**  
Compliant

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

**Findings:**  
Inspectors were satisfied that the provider ensured that complaints were listened to and an effective appeals process was in place as outlined in the centres policies and procedures on the management of complaints. The actions identified at the previous inspection had been addressed.

There was a complaints policy and procedure which had been reviewed since the last inspection. It included the named designated complaints officer and the appeals process for the centre. Inspectors noted the procedures and policy also made reference to the Authority. This was discussed with the provider who undertook to review reference to it.

At local level complaints were recorded, and if not resolved at this point, were referred to the complaints officer for investigation. The complaints log for 2014 was reviewed. Inspectors found each complaint was investigated and the outcome and satisfaction of the complainant was recorded. There was evidence that complainants were responded to and kept informed. The provider was also the nominated person who oversaw complaints were responded to and reported. He outlined a number of complaints investigations currently being undertaken and an update was provided to the inspectors during the inspection.

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**Outcome 14: End of Life Care**

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

**Theme:**  
Person-centred care and support

**Judgement:**  
Compliant

**Outstanding requirement(s) from previous inspection:**  
Some action(s) required from the previous inspection were not satisfactorily implemented.
**Findings:**
Inspectors found residents received care at their end-of-life that met their physical, spiritual and emotional needs. However, there were some improvements found in the care planning process.

There was a comprehensive end-of-life care policy in place that was currently being revised. Inspectors reviewed the files of residents, including one resident approaching end-of-life. There was evidence of assessment and discussion held around end-of-life care. All residents had an end-of-life care plan however, an area of improvement was identified. For example, care plans did not consistently guide care in terms of the religious beliefs and preferences of residents. This was an action at the previous inspection and not fully addressed. It is discussed under Outcome 11. Inspectors saw documented evidence that care plans were drawn up in consultation with the resident and/or their family members.

The person in charge stated that the centre maintained strong links with the local palliative care team. The staff were knowledgeable of the residents end-of-life preferences.

Residents and visitors were facilitated to visit loved ones at any time. There were facilities available for families to stay overnight with their loved ones. A family room was available with tea making and rest facilities provided. Residents were facilitated to pay their respects and the provider and person in charge ensured families and loved ones were provided with the relevant information and support at a residents passing.

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**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.*

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<thead>
<tr>
<th>Theme:</th>
<th>Person-centred care and support</th>
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<tr>
<td>Judgement:</td>
<td>Non Compliant - Major</td>
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**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.

**Findings:**
Inspectors were not satisfied that residents were provided with choice of meals at mealtimes and in accordance with their assessed needs, or that assistance was offered in a discrete and sensitive manner where required.

Inspectors were concerned that the staff practices observed throughout the two day inspection did not afford residents with assistance in a discreet or a sensitive manner that enabled them to eat and drink. Inspectors found the mealtime was a rushed
unsociable experience for residents, and observed the following:

1. The meal time experience was a hurried occasion for some residents particularly for those who required assistance. For example, inspectors observed that one resident was being offered spoonfuls of food in quick succession before they had time to swallow and enjoy their previous spoonful by a staff member.
2. On both days of the inspection, some residents were not offered any drink for the duration of the meal. This was only provided when a resident and inspectors raised this with staff.
3. Inspectors observed that some residents were not appropriately positioned either before, during or after their meal. Two residents were observed to be in a semi-recumbent position for the duration of their meal time which may pose a risk of choking. This matter was raised by inspectors and addressed.
4. There was inconsistency in the assistance being provided to residents. For example, on the first day of inspection inspectors observed a resident being assisted to eat his meal at a very rapid pace. On the second day, after inspectors had brought this to the attention of management, the same resident was observed eating his meal independently.
5. Some of the staff did not use the mealtime opportunity to speak to or communicate with the residents and assisted residents in silence.
6. On the first day of the inspection staff members stood over residents whilst assisting them with his meal, which gave the impression that the meal was hurried. These staff members did not communicate with the residents throughout the mealtime. This was raised with the person in charge on the first day of inspection and was again observed on day two of the inspection.
7. Inspectors did not observe any residents being offered second helpings.
8. Gravy was poured over meals without any consultation with residents. Staff were also observed adding a portion of butter to a residents meal before mixing it all together, again this practice limited residents choices. The catering staff confirmed that this was not required as all meals were already fortified before they left the main kitchen.
9. Some of the meals were served in a modified format, inspectors observed staff mixing it all up and pouring gravy over it prior to assisting the resident with the meal. This practice limited the residents choice of food and altered the consistency of the meal prescribed by the speech and language therapist.
10. While there were two main course lunch options daily for residents who were not on a modified consistency diet, resident’s food choice was limited as the staff did not offer choice to the residents. Inspectors observed fish and chicken that had been sent from the kitchen was not offered to residents.
11. Inspectors observed that the correct modified consistency diet prescribed for one resident by the speech and language therapist was not requested. This was raised by the inspector prior to the meal on day one of the inspection.
12. Overall staff were not familiar with the consistency of meals to be provided to residents and the list in the kitchen did not correspond with the list in the main kitchen or the list used by the catering assistant.
13. Inspectors were concerned about the availability of modified consistency snacks for residents in the evening time. The only options in one of the units were banana and yogurt. These arrangements were not based on the needs or preferences of individual residents and were not suitable for a resident who had a poor appetite and required small portions offered regularly during the evening.
14. Inspectors found that some residents who were underweight were prescribed supplements in addition to their high calorie diet, however, there was no evidence in the daily record sheets for a period of one week that the resident was receiving any diet apart from supplements. Other staff could not tell inspectors if residents with constipation were provided with a high fibre diet or appropriate fluid intake as per their care plans. Staff said the residents get what comes from the kitchen and did not know if it was high fibre.

15. Inspectors found that the mealtime experience was not pleasant or a social occasion for the residents.

As inspectors were so concerned about meals and the mealtime experience they reported their concerns to the person in charge on day one of the inspection and to the provider on the morning of day two of the inspection, however despite the feedback provided, it was not appropriately responded to and the experience and safety of residents at the meal time did not improve on day two of the inspection.

### 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.

#### Theme:
Person-centred care and support

#### Judgement:
Non Compliant - Major

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

#### Findings:
Inspectors were not satisfied that the centre was managed in a way that maximised residents capacity to exercise personal autonomy and choice and that routines and practices did not maximise residents independence. There was evidence of consultation with residents in how the centre was planned and run.

Inspectors found residents were not consistently enabled to exercise choice over their life to maximise their independence. For example, the requests of residents were not responded to or carried out by staff on a number of occasions during the inspection, this is discussed under Outcome 6. Also residents were observed receiving inappropriate support at meal times as outlined in Outcome 15, and some residents reported to inspectors that they were not offered or asked if they wished to be included in activities.

Inspectors also observed the procedures in place to protect residents privacy were not robust. For example, tables in one unit had been set with personalised table mats for
each resident that contained confidential information about the residents dietary needs. This had been raised at the previous inspection and continued to be an issue. Inspectors were concerned that personal information of this nature continued to be publicly displayed in such a manner. The table mats were removed by the person in charge when brought to her attention.

There were arrangements in place to facilitate consultation and participation with residents in the organisation of the centre. A residents’ committee met every two months. Inspectors read minutes of the meetings which confirmed issues raised were followed up and addressed. For example, residents raised the choice of meals available in the evening time. This issue had been reviewed, and a recent meeting with the dietician and catering staff had taken place. Copies of new menus for the evening meal where seen by inspectors and they now included a larger range of choice for residents at this time.

Religious and spiritual needs of residents were respected. The person in charge outlined the services available to the residents. Mass was celebrated in the centre three days a week.

**Outcome 17: Residents clothing and personal property and possessions**

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

**Theme:**
Person-centred care and support

**Judgement:**
Compliant

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

**Findings:**
Inspectors were satisfied residents had sufficient space for their personal belongings and their clothes were suitably laundered and returned to them. The action from the previous inspection was addressed.

Inspectors observed and residents confirmed, that they were encouraged to personalise their rooms. There was an up-to-date record of residents' personal belongings maintained on their file. A number of bedrooms were decorated with pictures and photographs from residents’ own homes. Residents had private lockable space to store personal valuables.

Clothing items were clearly marked with the name of the resident. Inspectors visited the laundry service on the grounds of the centre and suitable facilities and procedures for the safe laundering of clothing were provided. Inspectors talked to residents who
confirmed they were satisfied with the way in which their clothes were cared for and were happy with the service.

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Workforce

Judgement:
Non Compliant - Major

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

Findings:
Inspectors found that there were sufficient staff levels and skill mix to meet the assessed needs of residents however, the supervision and management of staff to ensure the provision of appropriate care and supervision of residents was not evident at all times. This has already been referred to in outcomes 6 and 15. Improvements were also required in the staff documentation required to be maintained by the Regulations.

There was an actual planned roster seen by inspectors that confirmed an adequate number of staff and skill mix met the needs of residents. However, inspectors were not satisfied that staff responded in a timely manner to residents needs at different times of the inspection. For example, as outlined in Outcome 6, inspectors observed residents calling for assistance in the morning. There was also a lack of response by staff to residents calling for assistance during mealtimes as seen under outcome 15. Residents informed inspectors there was not enough staff around in the morning time. In one unit staff told inspectors that staff breaks resulted in three out of the six staff off the floor at any one time. This left just three staff to provide care for residents. Additionally, the movement of staff to other units due to leave or absence on some days of the week, resulted in up to three staff being rostered to other units and an overall reduction of staff in the unit.

Inspectors were not satisfied that the supervision of staff appropriate to their role was adequate. This was evident in the poor outcomes for residents as outlined above, and in outcomes 6, 15 and 16. Furthermore there was no appraisal system for staff. These matters had been discussed at the previous inspection and no progress had been made in this area.

There was a nurse on duty on each of the four units at any one time. Rosters read for
the four units in the centre confirmed up to eight staff were on duty between 7.15hrs and 1.15hrs including up to six nurses. At night time, one nurse and one health care assistant were on duty, with an additional nurse manager covering night duty. The provider outlined to inspectors a plan to introduce a "twilight" shift in the evening time on each unit. This would address issues raised in the last inspection regarding staff levels in the evening. It was hoped this arrangement would commence by the end of May 2014.

Whilst there were improvements in the staff documentation required to be kept by the Regulations, some gaps were identified. A sample of staff files were reviewed. However, they did not contain all information required, for example, two files did not include evidence of the fitness of staff to work. This had also been an action at the previous inspection and was not addressed.

There was a training programme in place for all staff. Records read by inspectors confirmed all staff had up-to-date mandatory training and received education and training to meet the needs of residents. Records confirmed staff had attended a range of training in areas such as the management of restraint, wound care and nutrition. However, the learning in these areas was not incorporated into practice by all staff as outlined in outcomes 11 and 15.

There were a number of volunteers who provided an invaluable service to the residents. Records seen confirmed volunteers had An Garda Síochána vetting and a written agreement that set out their roles and responsibilities.

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Deirdre Byrne  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
**Provider’s response to inspection report**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Clonskeagh Community Nursing Unit</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000491</td>
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<tr>
<td>Date of inspection:</td>
<td>07/05/2014</td>
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<tr>
<td>Date of response:</td>
<td>04/06/2014</td>
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**Requirements**

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

**Outcome 01: Statement of Purpose**

**Theme:** Leadership, Governance and Management

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

The statement of purpose did not include all the information outlined in Regulation 5 and Schedule 1 of the Regulations.

**Action Required:**

Under Regulation 5 (1) (c) you are required to: Compile a Statement of purpose that consists of all matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

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

The statement of purpose has been revised to incorporate all nurse management grades within the centre and an overview is outlined within relative to complaints management and fire evacuation procedures.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The Registered Provider is currently securing enhanced floor plans (increased scale) which will clearly demonstrate room sizes as required within the statement of purpose.

Proposed Timescale: 30/06/2014

**Outcome 03: Suitable Person in Charge**  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge did not demonstrate sufficient clinical governance and leadership to ensure the centre was managed with accountability and authority.

**Action Required:**
Under Regulation 15 (1) you are required to: Put in place a person in charge of the designated centre.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will be deploying an experienced Person in Charge to the role within this care centre.

The Registered Provider will ensure that appropriate assistance and support is available to the new PIC to ensure that the necessary clinical governance and leadership is delivered within the Centre.

Proposed Timescale: 30/06/2014

**Outcome 04: Records and documentation to be kept at a designated centre**  
**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The insurance cover in place did not fully meet the requirements of the Regulations.

**Action Required:**
Under Regulation 26 (2) you are required to: Put insurance cover in place against loss or damage to the property of residents including liability as specified in Regulation 26 (2).

**Please state the actions you have taken or are planning to take:**
The Registered Provider is advised by their broker that appropriate insurance cover is in place for residents in compliance with Sec 26 (2) – Part 7 of the Regulations. A copy of this communication will be forwarded to the inspectorate for reference purposes.
Proposed Timescale: 04/06/2014
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy relating to risk management and the protection of vulnerable adults required additional information to provide direction to staff.

Action Required:
Under Regulation 27 (1) you are required to: Put in place all of the written and operational policies listed in Schedule 5.

Please state the actions you have taken or are planning to take:
The Risk Management Policy will be amended to include more specific direction(s) to staff and management at the Centre in terms of the identification, evaluation, management and escalation of risk. The process in place presently is focused on the continuous risk analysis within the centre and this approach needs to be enhanced further through better communication and reaffirming each and every staff members responsibility in this regard.

The Register Provider will focus more training and on-site evaluation to achieve the necessary improvements.

Proposed Timescale: 31/07/2014

Outcome 06: Safeguarding and Safety
Theme: Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Suitable and sufficient care to maintain residents wellbeing and welfare was not consistently provided.

Action Required:
Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

Please state the actions you have taken or are planning to take:
The Registered Provider and the PIC will be specifically focusing on achieving significant improvements in care delivery to our residents. The PIC will re-enforce a patient focused, responsive and engaging methodology in terms of delivering care and support to our residents.

The Registered Provider and PIC will be formally addressing these essential
improvements to all nurse managers initially and ensure appropriate supports are in place to achieve the necessary improvements. Nurse Management through the PIC will assume full accountability for the performance of their staff in this regard. The required improvements will be reviewed centre wide by the PIC and the Registered Provider on a monthly basis or on a case by case basis where the PIC indicates that this is required.

**Proposed Timescale:** 30/06/2014

<table>
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<th>Outcome 07: Health and Safety and Risk Management</th>
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<tr>
<td><strong>Theme:</strong> Safe Care and Support</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not meet the requirements of the Regulations.

**Action Required:**
Under Regulation 31 (1) you are required to: Put in place a comprehensive written risk management policy and implement this throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
The Risk Management Policy is being reviewed currently in order to better direct and inform staff and management on how to risk assess, communicate and evaluate risk, develop and put in place appropriate control measures, and escalate risk as required to the nominated person on behalf of the Registered Provider.

The Registered Provider has engaged external advice from a dedicated risk manager to further develop internal structures within the centre to enhance and streamline the risk management process and ensure that there is appropriate learning and practice improvements where audits indicated.

The PIC will ensure that the Integrated Quality and Risk Management forum will meet at least three monthly and that a focus will be maintained on promoting a pro-active approach to risk management within the centre on a day to day basis.

The Registered Provider will re-enforce this approach with additional on-site support and training including further centre wide training on the risk identification and evaluation process.

**Proposed Timescale:** 31/08/2014

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all areas of risk identified as outlined in Outcome 7 had comprehensive control measures in place to manage them.
Some areas of risk had not been assessed, for example the smoking room

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

**Please state the actions you have taken or are planning to take:**
The risk “area” referred to in this report was evaluated prior to the completion of the Inspection. However, the complete risk register will be re-evaluated by the PIC and the Registered Provider to ensure that risks are appropriately recorded and that all necessary control measures are undertaken and documented to mitigate such risks. The Registered Provider is anxious to ensure that matters necessitating escalation are identified and addressed immediately including the development of a comprehensive evacuation plan (partial and full) in the event of a critical incident on site.

In further developing the role and function of the integrated quality and risk forum the PIC will ensure that all control measures indicated are reviewed systematically in line with the risk register for the protection and welfare of residents and staff within the centre.

**Proposed Timescale:** 30/09/2014

**Theme:** Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There is no effective system of investigating and learning from serious incidents involving resident.

**Action Required:**
Under Regulation 31 (2) (d) you are required to: Ensure that the risk management policy covers the arrangements for the identification, recording, investigation and learning from serious or untoward incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
An integrated Quality, Safety and Risk Management Forum is in place within the Centre although it is noted that this forum had not met for some time (7 months). An essential element of the terms of reference of this group is to review all adverse events and/or incidents within the centre in order to identify systematic improvements in delivering care to the residents. The terms of reference of this forum will be re-enforced to ensure that all such data is recorded, analysed, risk rated, and that improvements identified through same are communicated widely throughout the Centre.

The new PIC will review the membership of this forum to ensure broader representation from staff and to put communication both to and from this forum on a formal footing.
The Register Provider will provide the necessary support to enable this and will further ensure that communication to and from the forum within the centre at to external parties is focused on and targeted at risk minimisation. The PIC will ensure that the risk management process is integrated within all functions within the centre and that appropriate timely actions are undertaken to protect and promote the welfare of our residents.

**Proposed Timescale:** 30/09/2014  
**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The emergency plan in place was limited to procedures to follow in the event of a fire.

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

**Please state the actions you have taken or are planning to take:**  
The Registered Provider and PIC will review the emergency plan in the context of recent training which was facilitated by the Registered Provider to all PIC’s within DML on the 24th of April 2014.

**Proposed Timescale:** 30/06/2014  
**Theme:** Safe Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The record of fire drills carried out did not include the length of time and outcome of each.

**Action Required:**  
Under Regulation 32 (1) (e) you are required to: Ensure, by means of fire drills and fire practices at suitable intervals, that the staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire, including the procedure for saving life.

**Please state the actions you have taken or are planning to take:**  
The PIC will ensure that the person (ADON) undertaking the review of such procedures/drill(s) records the time event on each occasion.

**Proposed Timescale:** 04/06/2014
**Outcome 08: Medication Management**

**Theme:** Safe Care and Support

*The Registered Provider is failing to comply with a regulatory requirement in the following respect:*
Medication administration practices were not consistently in line with the centres policies or professional guidelines.

There was no effective system of auditing medication practices.

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

**Please state the actions you have taken or are planning to take:**
The PIC will ensure that the audit undertaken by the Pharmacist is completed in order to further inform/identify potential deficiencies in practice. The PIC will be re-enforcing the policy in practice with the Clinical Nurse Managers and carrying out intermittent inspection and increased levels of observation to ensure full compliance with our policy on medication management.

**Proposed Timescale:** 31/07/2014

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**Outcome 09: 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:*
Allegations of staff misconduct were not notified to the Chief Inspector.

**Action Required:**
Under Regulation 36 (2) (f) you are required to: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation of misconduct by the registered provider or any person who works in the designated centre.

**Please state the actions you have taken or are planning to take:**
The Registered Provider has investigated the reason as to why two such incidents were not notified to the Chief Inspector despite previous deficiencies identified through past Inspections and assurances being given in the latest Improvement Plan.

The Registered Provider accepts that the nominated person within the Centre failed to recognise that the occurrences were “notifiable incidents” Performance in this regard will be reviewed by the PIC going forward. The Registered Provider is satisfied that both incidents were full investigated and that appropriate action was undertaken following on
from the investigation(s). The incidents were subsequently notified to the Health Information and Quality Authority in the prescribed manner.

**Proposed Timescale:** 04/06/2014

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

**Theme:** Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system of review of the quality of life of residents was not robust to effect change or drive improvement.

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

**Please state the actions you have taken or are planning to take:**
Much of the information (audits) reviewed by the Inspectors at the most recent Inspection had only been recently initiated (March) post the Improvement Plan following on from the Inspection in January 2014. This information had yet to be fully analysed and developed into a coherent plan in order to effect the appropriate improvements/actions identified within the audit(s)

The PIC will review this information with the assistance of the support person (who will be reviewing care planning) in order to incorporate new approaches and or consider alternatives with a view to attempting to reduce falls and the use of prescribed forms of restraint.

The Nominated Person on behalf of the Registered Provider is committed to supporting the PIC to review Infection Control Standards through audit to be carried out by a recently recruited resource within the Community (HSE Community Services).

The PIC will maintain focus on these essential improvements through the development and further enhancement of the multi-disciplinary forum within the centre. The PIC will ensure that all disciplines are engaged in informing and improving service delivery and improvements in clinical practice, whether these relate to individual residents of indeed where systematic changes in the delivery of care within the centre is required. The PIC recognises the importance of the involvement of all disciplines towards improving the quality of care to all residents within the Centre and is committed to strengthening the involvement of the allied health professionals in this regard.

The PIC will initiate a daily report on the use of restraint(s) in order to maintain a close overview on levels of restraint within the Centre, to ensure appropriate prescribed usage and to ensure that all possible alternatives are considered and documented where appropriate.
The PIC will ensure that all residents and/or their families/next of kin are advised when audits are initiated and/or planned to ensure that they are given every opportunity to inform such audits in order to reflect service user involvement in the continuous improvement of services to the resident. A key element of Multi-Disciplin ary Group (incorporating the CNM’s) will be to communicate audit outcomes and service improvement plans from same to all staff within their area of responsibility.

**Proposed Timescale:** 30/09/2014

### Outcome 11: Health and Social Care Needs

**Theme:** Effective Care and Support

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

The management of residents health care needs in relation to nutrition, behaviours that challenge, restraint and continence care required improvement.

**Action Required:**

Under Regulation 6 (3) (a) you are required to: Put in place suitable and sufficient care to maintain each residents welfare and wellbeing, having regard to the nature and extent of each residents dependency and needs.

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

The Registered Provider will be offering a dedicated resource to assist the PIC to ensure appropriate improvement is achieved in the area of care planning within the Centre. This resource will focus on audits already underway within the centre to ensure continuous improvement and identify weaknesses, both systematic and those relating to individual staff performance where evident. This resource will focus training and education within the centre initially at Clinical Nurse Manager grade to ensure competence and accountability is fully understood and embraced.

The Registered Provider and PIC are committed to delivering appropriate support and training to ensure that significant progress is being achieved.

**Proposed Timescale:** 30/09/2014

**Theme:** Effective Care and Support

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

Not all residents had opportunities for social engagement

**Action Required:**

Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.
Please state the actions you have taken or are planning to take:
The PIC is particularly conscious of the opportunities that exist within the Centre to enhance opportunities for social engagement for our residents. A centre wide audit is underway to assist in informing what additional activities are desirable from the residents’ perspective.

The PIC will be ensuring that staff engage in identifying and delivering opportunities with residents for further social engagement and activities both within and outside of the Centre. The PIC will focus such efforts outside of current activities particularly at times during the day when the resident requires stimulation and socialisation. The PIC is acutely aware that many residents do not engage in meaningful activities and will be reviewing the results of the activities audit by the co-ordinator together with feedback from the AHP’s and staff to identify and deliver further opportunities for social engagement for such residents.

The Registered Provider is committed to supporting the efforts of the PIC in this regard.

**Proposed Timescale:** 31/07/2014

**Theme:** Effective Care and Support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans do not consistently direct the care to be delivered to residents.

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

Please state the actions you have taken or are planning to take:
The Registered Provider will be offering a dedicated resource to assist the PIC to ensure appropriate improvement is achieved in the area of care planning within the Centre. This resource will focus on audits already underway within the centre to ensure continuous improvement and identify weaknesses, both systematic and pertinent to staff where evident. This resource will focus training and education within the centre initially at Clinical Nurse Manager grade to ensure competence and accountability is fully understood and embraced.

The PIC and dedicated resource person (care planning) will focus on identifying champions within the centre (for care planning) in order to foster a level of “ownership” and competence to provide support on an ongoing basis to nursing staff.

The Registered Provider and PIC are committed to delivering appropriate support and training to ensure that significant and continuous progress is being achieved.
**Proposed Timescale:** 31/08/2014  

**Theme:** Effective Care and Support  

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Recommendations from allied health professionals are not incorporated into all residents' care plans.

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

**Please state the actions you have taken or are planning to take:**  
The Registered Provider will be offering a dedicated resource to assist the PIC to ensure appropriate improvement is achieved in the area of care planning within the Centre. This resource will focus on audits already underway within the centre to ensure continuous improvement and identify weaknesses, both systematic and pertinent to staff where evident. This resource will focus training and education within the centre initially at Clinical Nurse Manager grade to ensure competence and accountability is fully understood and embraced.

The Registered Provider and PIC are committed to delivering appropriate support and training to ensure that significant progress is being achieved.

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**Proposed Timescale:** 31/08/2014  

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**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 three-three bedded rooms do not meet the needs of residents.

The design and layout of the communal areas of the centre in each unit do not meet the needs of all residents.

The decor in parts of the centre was not homely in appearance.

The Chief Inspector requests a costed plan, with definite timeframes to address the premises deficits as outlined in the report and the action plan above to be submitted to the Authority.

**Action Required:**  
Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.
Please state the actions you have taken or are planning to take:

The three-bedded rooms referred to in the Inspection report are utilised and defined as short-stay respite beds. The Registered Provider has been advised by the Person in Charge that a waiting list is in existence in respect of the nine designated respite care beds within the centre. The PIC has undertaken to review all such current respite clients (including the frequency of their respite) to establish a programme whereby the nine beds can be reduced to six without negatively impacting upon our respite care clients in the short term. The Registered Provider is confident that such a plan would reach a level of compliance under 25.54 of the National Quality Standards for Residential Care Settings for Older People in Ireland. However, the Registered Provider and PIC are acutely aware that the loss of such capacity (3 beds) may have a significantly negative impact of current and future anticipated clients. The Registered Provider and Person in Charge provided the Inspector with a plan to reduce the three-bedded rooms to two bedded rooms at the conclusion of the Inspection on the 8th of May 2014.

In the interim, the internal decoration including client privacy screens have been reviewed and any necessary upgrade will be funded through minor capital funding allocated to the Centre for 2014. The PIC is currently endeavouring to identify alternatives to the current screens and has engaged with a specific manufacturer to develop an alternative design for the multi-occupancy rooms (both two and three bedded).

The Inspection Report indicates that each unit had a living and dining room which was small in size. The centre was designed with a dedicated dining/activities area on the ground floor which has adequate space for such activities. The Register Provider and Person in Charge encourage all residents to take meals and activities outside of their “normal” communal space and will again ensure that this choice is afforded to all residents and that staff are aware of their obligation to accommodate residents in their choices in this regard.

The Registered Provider has secured appropriate resources to implement programme of re-decoration at the centre. The programme of re-decoration commenced in May and will be concluded by the end of June 2014. The patient advocacy group have been central to such decisions. The PIC affords every reasonable opportunity to residents in their desire to personalise their dedicated rooms.

Proposed Timescale: 31/07/2014

Theme: Effective Care and Support

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

There was no provision of independently located toilets close to the communal areas on all floors.

Action Required:
Under Regulation 19 (3) (j) part 2 you are required to: Provide sufficient numbers of toilets and wash-basins which incorporate thermostatic control valves or other suitable
anti-scalding protection, at appropriate places in the premises.

**Please state the actions you have taken or are planning to take:**
The advices of a design architect have been sought in order to develop a plan for consideration by the Registered Provider to achieve the above standard.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was inadequate provision of storage space for assistive equipment.

**Action Required:**
Under Regulation 19 (3) (i) you are required to: Provide suitable facilities for residents to meet visitors in communal accommodation and a suitable private area which is separate from the residents own private rooms.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will review this matter with the new PIC and the Centre manager. Storage space is available on the ground floor and the Centre manager has reviewed all equipping needs to ensure only those essential for daily use are maintained on the units. This matter will be reviewed on an ongoing basis to ensure appropriate housekeeping and safe storage of equipment particularly during periods of non-usage.

The Registered Provider has approved centre specific external storage for those items not requiring ongoing use within the Centre. The new PIC will be reviewing care practices and management of the care environment to ensure appropriate storage of equipment and appliances.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was insufficient screening provided in the three-bedded rooms.

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

**Please state the actions you have taken or are planning to take:**
The PIC is currently endeavouring to identify alternatives to the current screens and has engaged with a specific manufacturer to develop an alternative design for the multi-occupancy rooms.
### 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:**
Residents on modified consistency diets did not receive meals in accordance with their assessed needs.

**Action Required:**
Under Regulation 20 (2) part 6 you are required to: Provide each resident with food and drink that takes account of any special dietary requirements and is consistent with each resident's individual needs.

**Please state the actions you have taken or are planning to take:**
The PIC has initiated urgent actions in respect of the above non-compliance. Every resident's meal is now delivered in accordance with the prescribed manner (in accordance with care plan) and all residents are offered a choice of meal as defined within the menu on offer at any given time. The PIC and nominees are reviewing this matter on-site (at each mealtime) on a daily basis with the household services manager to ensure that staff act in accordance with the prescribed dietary needs while ensuring that all residents receive their meals in a courteous and dignified manner.

**Proposed Timescale:** 04/06/2014

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| **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents were not offered a choice of food at mealtimes, and no choice was available to residents on a modified consistency diet. |
| **Action Required:**
Under Regulation 20 (2) part 5 you are required to: Provide each resident with food that is varied and offers choice at each mealtime. |
| **Please state the actions you have taken or are planning to take:**
This matter has been reviewed and residents prescribed as requiring a modified diet are now offered a choice of meals. |
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not provided with appropriate assistance at mealtimes in a discreet and sensitive manner.

Action Required:
Under Regulation 20 (4) you are required to: Provide appropriate assistance to residents who, due to infirmity or other causes, require assistance with eating and drinking.

Please state the actions you have taken or are planning to take:
As advised in response to 20 (2) part 6 above the PIC has initiated an on-site review across all Units of the manner in which residents are engaged with during mealtimes. The PIC has re-affirmed with all staff the necessity to engage appropriately with all residents ensuring that the necessary dignity and respect is afforded to each resident during this important period(s) of the day.

The Registered Provider has been provided with assurance that such processes have dramatically improved the dining experience for the residents within the Centre and will be ensuring that the situation is regularly reviewed through on-site inspections with the PIC and a nominated person from Quality and Standards.

The new PIC will be ensuring that the current quality food circle is strengthened to reflect the needs and views of residents particularly in response to the latest initiative to improve the dining experience of the residents.

Proposed Timescale: 04/06/2014

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
During the inspection appropriate snacks were not available in the evening for residents who were being monitored for weight loss.

Action Required:
Under Regulation 20 (5) you are required to: Provide meals, collations and refreshments at times as may reasonably be required by residents.

Please state the actions you have taken or are planning to take:
The PIC initiated a review of the availability and variety of snack options for residents in the evening. This review which incorporates the catering manager(s) will provider a broader range of snack options which where possible will be based on individual choice(s) within a range of options offered.
Proposed Timescale: 04/06/2014  
Theme: Person-centred care and support  

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
The processes in place to ensure residents do not experience poor nutrition and hydration required improvement.  

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

Please state the actions you have taken or are planning to take:  
The PIC will be supported by the Registered Provider to ensure that there is a comprehensive review of care planning within the Centre. As indicated in the response to Outcome 11 above the Registered Provider will be dedicating a senior manager from quality and compliance (HSE) to focus on care planning and to support the PIC in ensuring that all nursing staff fully inform (record on care plans) and comply with delivering care in association with the residents assessed needs and in accordance with their professional training and standards as prescribed by An Board Altranais.  

Proposed Timescale: 31/07/2014  
Theme: Person-centred care and support  

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:  
Water and drinks were not freely available or easily accessible to residents.  

Action Required:  
Under Regulation 20 (2) part 2 you are required to: Provide each resident with food and drink in quantities adequate for their needs,  

Please state the actions you have taken or are planning to take:  
This matter has been address and the PIC has focused particularly on this item following on from the de-briefing on the 8th of May 2014 with the Inspector(s).  

Proposed Timescale: 04/06/2014  

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:  
The residents were not enabled to maximize their independence or choice in the centre.
**Action Required:**
Under Regulation 10 (b) you are required to: Provide each resident with the freedom to exercise choice to the extent that such freedom does not infringe on the rights of other residents.

**Please state the actions you have taken or are planning to take:**
The PIC will be reviewing the work and focus of the Patient Advocacy Group with a view to having more frequent meetings while at the same time endeavouring to foster a level of confidence and openness within this forum which can assist in voicing how residents feel about choices or indeed the lack of choices which are afforded to them relative to their residency within the centre.

The PIC will also be advocating a suggestion box approach to assist in the above for residents and their families.

The Registered Provider and PIC are disappointed relative to the observations by the Inspectors during the most recent Inspection particular where it was evident that "requests of residents were not responded to or carried out by staff on a number of occasions during the Inspection" The PIC will not tolerate a culture where such observances are in place and will be re-affirming this position with all staff imminently.

This area of non-compliance has been addressed to all Clinical Nurse Managers to ensure awareness of accountability and responsibility for the actions/inactions of all staff. The PIC has re-affirmed the absolute importance of ensuring that residents are in all cases treated with appropriate dignity and respect and that all staff maintain a focus on responding and engaging with residents to deliver care and social engagement in a caring and responsive manner.

The PIC will be carefully reviewing such interactions with the support of the Registered Provider.

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**Proposed Timescale:** 04/06/2014  
**Theme:** Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Residents personal dietary information was displayed without their consultation.

**Action Required:**  
Under Regulation 10 (c) you are required to: Provide residents with privacy to the extent that each resident is able to undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**  
This has been addressed by the PIC in that all personal information relative to residents is not disclosed within the centre other than to individuals directly engaged in the provision of their care.
Outcome 18: Suitable Staffing

**Theme:** Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not respond to residents needs in a timely manner at different times of the day.

**Action Required:**
Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The Registered Provider and PIC are disappointed relative to the observations by the Inspectors during the most recent Inspection particular where it was evident that “requests of residents were not responded to or carried out by staff on a number of occasions during the Inspection” The PIC will not tolerate a culture where such observances are in place and will be re-affirming this position with all staff imminently.

This area of non-compliance has been addressed to all Clinical Nurse Managers to ensure awareness of accountability and responsibility for the actions/inactions of all staff. The PIC has re-affirmed the absolute importance of ensuring that residents are in all cases treated with appropriate dignity and respect and that all staff maintain a focus on responding and engaging with residents to deliver care and social engagement in a caring and responsive manner.

The manner in which all staff engage with residents will be closely observed and will be revisited with all Clinical Nurse Managers as a standing item of the management agenda within the Centre.

**Proposed Timescale:** 09/06/2014

**Theme:** Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had received training but the learning was not consistently implemented in practice for example, nutrition care.

**Action Required:**
Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.
Please state the actions you have taken or are planning to take:
The PIC with the support of the Registered Provider will ensure that appropriate training and education is afforded to individual staff where there is a desire to further education and experience or indeed where there are deficiencies in practice identified. The review of care planning centre wide will no doubt identify particular individuals and/or areas requiring improvement. The PIC with the assistance of the Registered Provider will make available on-site training and education to drive continuous improvement and promote leaders within the centre to help foster an in-service resource to promote best practice through a process of peer audit.

Proposed Timescale: 31/08/2014
Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no robust system of supervision of staff.

Action Required:
Under Regulation 17 (2) you are required to: Supervise all staff members on an appropriate basis pertinent to their role.

Please state the actions you have taken or are planning to take:
Please see response under 10 b Outcome 11 above. The PIC will be ensuring that there is a recurring process of engagement with Clinical Nurse Manager’s to support and develop skills towards improving direct supervision and management of staff. The PIC will be reviewing the relevant teams on each Unit to ensure that there is an appropriate mix of skills and competencies amongst the managers and staff.

The PIC and Registered Provider will be reviewing this performance on a continuous basis through evaluation of complaints, feedback from advocacy service and evaluation of performance reports from Clinical Nurse Managers.(Immediate)

The nominated person on behalf of the Registered Provider and the PIC are conscious of an action outstanding from the previous Inspection relative to concerns relating to apparent shortage of staff particularly during the twilight period. The PIC had proposed a review of the rosters in this regard which was undertaken in April. It is proposed to defer the implementation of any roster change until the new PIC and support person have had an opportunity to comprehensively review the dependency levels of all residents in parallel with the resources available at ward level throughout the day to manage such dependency.

Proposed Timescale: 31/08/2014
Theme: Workforce
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in the staff documentation required to be kept under Schedule 2 of the Regulations.

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

Please state the actions you have taken or are planning to take:
The PIC has sought additional (3rd) references for individuals identified through the latest Inspection. This item will be kept under review until the appropriate documentation is received. The PIC is not aware why such delays have been experienced other than “administrative delays” and has no concerns relative to the individuals where the omission (part) was identified.

Proposed Timescale: 31/07/2014