Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	St Joseph's Nursing Home
Centre ID:	OSV-0000169
Centre address:	Clones Road, Ballybay, Monaghan.
Telephone number:	042 974 1141
Email address:	olshballybay@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Congregation of the Daughters of Our Lady of the Sacred Heart
Provider Nominee:	Kathleen McQuillan
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	20
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
01 September 2014 09:30	01 September 2014 17:00
03 September 2014 09:00	03 September 2014 17:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was an eighteen outcome, announced inspection of the centre by the Health Information and Quality Authority (the Authority) in response to an application by the provider to the Authority to renew registration of this centre. The current registration of this centre is due to expire on 17 January 2015.

In order to apply for renewal of registration the provider must submit required documentation to the Authority. Prior to the inspection the inspector reviewed written evidence, from a suitably qualified person confirming the building meets all the statutory requirements of the Fire and Planning Authority, with regard to the use of the building as a residential centre for older people. A revised copy of this declaration of compliance with fire safety is required on satisfactory completion of

required actions by Monaghan fire services to complete the required documentation for progression of renewal of registration of the designated centre.

The Authority received four completed pre-inspection questionnaires, two completed by residents and two completed by relatives of residents in the centre. The feedback from these questionnaires was positive on all aspects of the service surveyed. The Inspector found that residents and relatives were also generally positive in their feedback to inspectors on the day of inspection and expressed satisfaction with the facilities, services and care provided. Residents who could verbalize their views were also complimentary about the meals provided, choices, the staff team who cared for them and the level of recreational activity provided.

Deirdre Hughes, commenced in the role of Person in Charge in October 2013 and together with the provider demonstrated good leadership and commitment to providing a quality service for residents. All members of the team were clear about their areas of responsibility and reporting structures and the management structure allowed for sufficient monitoring of, and accountability for, practice. The fitness of the provider was determined by interview during the previous registration inspection and of the person in charge earlier this year in addition to ongoing regulatory work, including inspections of the centre and level of compliance with actions arising from inspections.

As part of the inspection process, inspectors met with residents, relatives and staff members, observed practices and reviewed documentation such as care plans, medical records, risk management documentation, accident logs, policies and procedures and staff files.

Some required documentation required improvement including insurance details. While systems were in place to ensure a safe environment was provided to residents, all hazards identified were not documented as required with controls stated to mitigate associated risks. The premises were clean and well maintained. There were measures in place to protect residents from being harmed or suffering abuse. Residents had good access to medical and allied health care. Care planning documentation and assessment of residents' needs was found to be complete and ensured residents needs were fully documented and evaluated.

The staff team demonstrated their commitment to ensuring that the care and quality of life of residents was in keeping with their choices. There was evidence that residents were supported to remain independent and encouraged to pursue their past interests as much as possible. The centre's population is all female of which 55% were religious sisters.

Residents did not have safe access to a safe enclosed area and not all areas of the external environment accessible to residents who could independently leave the centre and visitors. These areas constitute major non compliance and are detailed in outcomes 12 and 16.

The action plan at the end of this report identifies areas where mandatory improvements are required to comply 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.

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
An up-to-date Statement of Purpose dated 04 September was forwarded to the Authority which reflected the service provided and included the revised management and governance arrangements that included deputising arrangements for the person in charge. Following the last inspection, room sizes were expressed in terms of meters squared and the appeal process was revised in response an action plan developed from findings from the last inspection of the centre in January 2014. There was evidence throughout the days of inspection to confirm that the contents of the Statement of Purpose document were clearly implemented in practice.

The provider was aware of her responsibility to ensure the Statement of Purpose document was kept under review and updated accordingly

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
There were sufficient resources in terms of staffing, skills and equipment to ensure effective delivery of care in accordance with the centre's statement of purpose. There was a clearly defined management structure that identified the lines of accountability and authority. The provider and person in charge worked full-time in the centre and managed its day to day operation together. An auditing schedule was established to ensure aspects of the quality and safety of care and the quality of the residents' experience in the centre were monitored. The inspector reviewed evidence of safety audits including a health and safety audit completed on 13 August 2014, monthly accident and incident review, review of psychotropic medication use, an annual pharmacy audit and a review of the dining experience for residents among others. There was evidence of improvements made as a result of reviews such as revision of the activity schedule to better reflect the interests and choices of residents. The inspector found that while key information was collated in data collection, analysed and actions to be completed identified and done in most cases, not all information analysed informed improvement. For example; an analysis of resident falls for the period March to June 2014 did not highlight that 90% of resident falls occurred between 00:30 and 05:40hrs. In addition, concomitant quality improvement plans were not consistently developed as part of the quality improvement process to include details of the actions to be taken, completion timescales and delegation of a designated person with responsibility for completion to ensure there was timely resolution of deficits identified from analysis of audit data collated.

The inspector found ample evidence that consultation with residents was of high importance to the provider and person in charge. Residents were consulted about many aspects of life in the centre and this finding was supported by actions taken by the management team in response to resident feedback. In addition there was also evidence that where able, residents were empowered to be involved in the running of the centre, for example; one resident ensured that individual cups were filled with water in readiness to be given by staff to residents to assist them with swallowing the communion host at daily mass. The inspector was told by the provider that a summary report of quality and safety reviews was being developed for availability at the end of the year.

The provider was working with Monaghan fire services to complete a schedule of required work to bring the centre into compliance with fire safety legislation following their inspection on the 21 August 2014. This work was in progress and the provider was aware that a revised declaration of fire safety was required by the Authority on completion as part of the registration renewal application.

Judgment:
Non Compliant - Major

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
There was a residents' guide available which was reviewed by the inspector. It contained all the information as required by the legislation. The information in this document functioned to assist prospective residents to make a decision regarding choosing a placement and also informed current residents of the services available to them.

Each resident had a written contract of care which outlined the services provided and the fee to be paid to the centre. Charges for other services available to residents were included. The centre did not charge residents for social activities. All contracts of care were signed and dated. The inspector observed that many residents signed their own contract of care.

Residents had access to a hairdresser who attended the centre; a price list was displayed in the hairdressing salon to enable residents to make a choice about the service they required.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Deirdre Hughes is the Person in Charge of the designated centre since January 2014. She works on a full-time basis, is a registered general nurse and has completed a postgraduate course in gerontology nursing. She has experience of being in the role of person in charge in three other designated centres since 2005.
The person in charge facilitated both days of this inspection. She provided documentation and information as required. She demonstrated that she was engaged in the governance, operational management and administration of the centre on a consistent basis. The person in charge was knowledgeable about individual resident's needs and their individual choices. Residents knew the person in charge and the inspector observed residents consulting with her accounting various queries they had which she responded to.
The inspector found adequate evidence of positive developments made since she commenced in her full-time person in charge role in January 2014 to support resident care pathways and to strengthen the clinical governance and management arrangements in the centre. For example, introduced a safer medication management system and reviewed and introduced new care plan documentation to strengthen resident assessment and documentation of resident care needs. Inspectors observed that the provider and person in charge worked as a team and the person in charge attended the provincial meetings with the provider

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
All of the written operational policies as required by schedule 5 of the Regulations were available. Policies, including the medication management policy and documentation advising procedures for safeguarding of residents' finances had been reviewed since the last inspection in January 2014.

The inspectors examined the employment documentation to be held in respect of four staff working in the centre and found that these were complete on this inspection.

The inspector found that records required by current legislation were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval with the exception of commentary records of fire drills held in the centre and is discussed in Outcome 8 in this report.

The directory of residents was reviewed by the inspector and was found to be complete with the exception of cause of death in respect of some residents referenced.

The inspectors were provided with copies of the staff rotas and staff files as requested which were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced the full name of all staff working in the centre and hours of duty as required.

Residents care plan documentation reviewed was accurately documented and daily nursing progress notes informed residents’ progress.

The centre's insurance details forwarded did not clearly reference cover against loss or damage to a resident's property as required.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
The provider and person in charge were aware of their responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The deputy person in charge was working in the centre on the day of the inspection and was met by an inspector. The person in charge had not been absent from the centre for more than 28 days to date.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
The inspector found that there were satisfactory arrangements in place to safeguard residents on this inspection. Arrangements were put in place following findings requiring improvement during the last inspection of the centre in January 2014 in relation to control of public access to residents' accommodation. A key-coded door was fitted in response that controlled public access to residents' accommodation on one side and facilitated freedom of access to residents on the other side.

There were no recorded incidents of alleged or confirmed abuse of residents in the

centre. The provider and person in charge expressed a no tolerance attitude towards abuse. The policy document informing protection of residents in the centre including the actions that should be taken by staff to care for residents in the immediate and short-term period following an allegation or incident of the various forms of abuse was reviewed to ensure clarity of procedures to be followed.
All staff files reviewed had evidence of completed appropriate vetting procedures. Staff spoken with were aware of their obligations and the procedures to follow in reporting and managing an incident of resident abuse. Residents confirmed to inspectors that they felt safe and secure in the centre. Many residents spoken with expressed their confidence in staff and spoke of their respectful attitude, kindness and patience towards them.

Resident finances were reviewed as part of this registration renewal inspection process. The provider acts as agent for collecting some residents' pensions and some residents' monies was lodged into their named account within the account for the centre. On review of this practice, inspectors found that all procedures involving residents' finances were transparent and residents were able to access their money when they wished. Supporting policy and procedural documentation to inform management of residents' finances were reviewed following the last inspection as detailed in an action plan following same to ensure that all aspects of this arrangement was supported and informed by a comprehensive policy.

A policy document was in place to inform management of behaviour that challenges exhibited by residents and promotion of a positive approach to managing same whilst supporting the resident concerned. The person in charge informed the inspector that none of the residents currently residing in the centre exhibited behaviour that challenged. Some staff had attended training in managing challenging behaviour and further training was scheduled for 04 October 2014.

Judgment:
Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
A Safety Statement was available dated 22 July 2014. A comprehensive risk management policy was in place that advised staff on the process for risk identification, assessment including measuring level of risk and mitigation with setting of control measures. Policies to advise on management of aggression and violence, accidental

injury to residents, visitors and staff, self-harm, the unexplained absence of a resident and abuse were available and recently reviewed to ensure they were in line with best practice. Each resident at risk had a missing person profile in place for use in the event of them leaving the centre unaccompanied to assist the emergency services to expedite their safe recovery. The policy advising on the management of residents who were at risk of self-harm was supported by some staff having received training on suicide alertness. Arrangements were in place for investigating, and learning from serious incidents and adverse events involving residents. There was also evidence of proactive accident prevention in the centre with procedures put in place to mitigate risk of reoccurrence. An emergency policy dated 20 May 2014 documented the arrangements for responding to emergencies which included the identification of a place of safe refuge for residents in the event of evacuation of the centre being required with arrangements for transportation and additional supplies of blankets and support resources.

There was some evidence that the health and safety of residents, staff and visitors was protected but required improvement to ensure there was no hazards in the centre that placed those accessing the centre at risk of injury. While the risk register had been reviewed there were a number of risks identified during the inspection by the Authority that were not recorded in the hazard identification documentation with concomitant controls in place. These hazards included the following:
- absence of handrails on some corridors on the first floor,
- absence of footpaths along the avenue
- a footpath through the front garden, the surface of which was in a hazardous condition
- inadequately secured boundary edges of some hard surfaced areas located at the back and side of the centre.

Some work had been completed to restrict access to the footpath through the front garden during the days of inspection in response to this finding. During the last inspection in January 2014, the inspectors were informed that two residents with medical conditions that manifested in a tendency to wander were among the resident group living in the centre; one of these residents was accommodated on the first floor and was at risk of accessing an open stairs as the access door to the stairs was not controlled. On this inspection, the inspector observed that access through this door to the stairs had been controlled in addition to procedures to control access by vulnerable residents to a ramped area of a corridor on the ground floor and installation of stair gates to control access to the stairs by residents at risk of falling. The risk posed by traffic on the site and car parking within close proximity was identified with calming and alert measures as part of the controls were in place. The inspector observed that uneven external roadway surfaces posed a risk to vulnerable residents during the inspection in January 2014. Resurfacing had been completed as part of the action plan from the last inspection and the inspector observed that this risk had been substantially mitigated by this action.

The local community attended Mass in the centre's Church and accessed the Church through the centre's main door, although a sign-in procedure was in place as observed during inspection in January 2014, access to the residents' accommodation was not adequately protected. The inspector observed on this inspection that a door had been installed with controlled access which assured the safety and privacy of residents in the centre without restricting access to the church by the local community. Residents who

were able were aware of the access code on the front door and the inspector observed a resident using it.
All staff had attended moving and handling training facilitated every two years. The inspector observed that moving and handling risk assessments were completed for each resident and procedures observed during the days of this inspection were carried out safely in line with best practice.

Each resident had a falls risk assessment completed. Resident falls were subject to audit by the person in charge. The inspector reviewed the resident incident and accident log and while there had been no serious accidents or incidents to residents since the last inspection in January 2014, 90% of documented resident falls occurred in the period between 00:30 and 05:40hrs. This finding was not apparent from the centre's falls review and is discussed further in Outcome 2 of this report.

The provider was working with Monaghan fire services to complete a schedule of required work to bring the centre into compliance with fire safety legislation following their inspection on the 21 August 2014. This work was in progress and the provider was aware that a revised declaration of fire safety was required by the Authority on completion as part of the registration renewal application. This requirement is documented in an action plan in Outcome 2 of this report. During inspection by the Authority in January 2014, inspectors found that seven members of staff had not attended fire safety training. This action was completed on this inspection and the training records confirmed all staff had attended fire safety training and had participated in a fire evacuation drill. Staff spoken with by the inspector were knowledgeable regarding appropriate actions to take in response to the fire alarm sounding. The inspector found that fire safety equipment was available and serviced as required. Records of fire preventative and safety checks were maintained including a daily laundry checking procedure completed by staff at the end of each day. All residents had evacuation risk assessments completed and documented for reference if required in an emergency; discretely displayed in their bedrooms, in large print and in a list maintained in the staff office which was updated at least monthly. The personal evacuation plans for each resident accounted for their day and night-time evacuation needs. The inspector observed that residents had adequate means of escape in the event of fire, all final fire exit doors were push-bar enabled. All fire exits were unobstructed as observed on the days of inspection. Fire evacuation drill records were reviewed which were simulated to represent day and night time situations. While there was some commentary available, this required improvement to reference all aspects of the drills completed. In addition, it was not clear if evacuation was from one zone to another or outside the building. The provider resided on the centre premises and was available on-site to support staff at night in the event of an emergency in the centre.

While the medication storage area had adequate alcohol hand gel available for hand hygiene purposes, there was no sink available in this area.

Judgment:
Non Compliant - Moderate

Outcome 09: Medication Management
Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:
Safe care and support

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

Findings:
Following findings requiring improvement and detailed in an action plan from the last inspection of the centre in January 2014, the medication management policy was revised on 05 August 2014 to include reference use of a pain assessment tool, monitoring of analgesia and use of PRN medications. An accredited pain assessment tool was in use to inform the management of residents experiencing pain. All Staff Nurses have completed a medication management update for 2014. The medication delivery system introduced by the person in charge in January 2014 was found to be established. It eliminated the need for nurse transcribing of residents' medication prescriptions. The inspector observed that the centre's medication management practice was supported by a pharmacist who was available to residents.
Some residents medications were administered in crushed format as prescribed by their GP to meet their needs. Additional information to inform staff with medication preparation and administration was documented by the pharmacist, however, there was no reference document available to staff to advise of potential interactions of medication mixing or altered effects when administered in crushed format.

The inspector attended a medication administration round and observed that hand hygiene between administration of medication to residents was satisfactorily completed on this inspection. The inspectors reviewed medication prescription and found that discontinued medications were signed and dated by a GP and the maximum dose in twenty four hours was also documented for medications prescribed on a PRN (as required) basis. Anticoagulant medication prescribing was enhanced with the implementation of a newly formatted record that included resident identification details. Photographic identification was in place on residents' prescriptions as required for identification checking procedures to ensure the correct medication was administered to the correct resident. Controlled medication was managed and stored in line with legislative requirements.

Medication was securely stored in an ante area off the staff office. While there was satisfactory use of hand hygiene alcohol gel, there was no sink available in this area. This finding is discussed in Outcome 8 of this report.

Judgment:
Non Compliant - Minor

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

Theme:
Safe care and support

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

Findings:
There were two actions to be completed following findings of non-compliance referenced following the last inspection of the centre in January 2014 in relation to failure to forward one notifications of serious injury within specified timeframes and incomplete quarterly notification of other accidents/incidents involving residents. These notifications have now been forwarded as required.

The inspector found from review of the centre's accident and incident log that incidents/accidents subject to a requirement for notification to the Authority were forwarded in line with the legislation.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
This outcome was satisfactorily met on this inspection, Findings during the last inspection in January 2014 resulted in action plans being forwarded to the provider and person in charge to address completeness of documentation to reference all care needs of each resident following assessment using an accredited assessment tool, an accredited assessment tool was not used to assess and monitor residents pain and all residents cognitive status was not regularly assessed. The inspector found that these

action plans were satisfactorily completed on this inspection.

The inspector found that suitable and sufficient care to maintain resident's welfare and well-being was in place on this inspection. Systems were in place for residents' assessment pre and post admission. All residents had a care plan to assist them in meeting their needs. At the time of this inspection there were twenty residents living in the centre. Ten residents had maximum dependency needs, five had high dependency needs, four had medium dependency needs and one resident had low dependency needs. 18(90%) of residents were aged between eighty and one hundred years. Residents had a mixture of age related medical conditions and cognitive impairment. Five (25%) residents in the centre have a primary diagnosis of alzheimers disease or dementia.

Since the last inspection in January 2014, the person in charge had reviewed and reformatted all care plans and assessment tools in use, and updating each resident's individual file in a new format. From an examination of a sample of residents' care plans and discussions with residents and staff, the inspector was satisfied that the nursing and medical care needs of residents were assessed and appropriate interventions and treatment plans were in place. Risk assessments were completed for each resident and included, moving and handling assessment, falls, use of bed rails, nutrition, continence and the risk of developing pressure related skin breakdown. Assessments of need informed care plans. Evaluations in daily progress notes reviewed were adequately informative and linked to the care plans reviewed. There was insufficient evidence of resident involvement in care plan reviews and reviews were consistently completed every three months for each resident.

From observation, review of residents' documentation and information received from residents, the inspector found that the provision of social care and support was delivered to achieve the best outcomes. An activity co-ordinator facilitates residents' socialisation and recreational activities for residents over the seven days each week. There were opportunities for residents in the sitting room to participate in activities that were meaningful and purposeful to them and reflected their interests and capacities. Each resident's interests had been collated to inform the programme of activities provided. Some residents were unable to leave their bedroom due to the nature of their underlying illnesses. The inspector observed gentle music playing in the background in one twin room accommodating two residents who were unable to go to the sitting room during the day. In addition they were afforded one to one opportunities to participate in gentle activation such as hand massage. The centre employed the services of an activity co-ordinator six days, Monday to Saturday each week and an aroma-therapist who also carried out hand and foot massage on a Thursday. The sitting room was arranged and equipped in a way that facilitated adequate freedom for residents to pursue their choice of activity without distraction from other activities taking place. Residents' life histories were completed and a
programme of activities was in place to suit their individual interests.
The person in charge informed the inspector that there was no resident exhibiting behaviour that challenges at the time of inspection. She confirmed that they had good input from mental health services who attended the centre as requested.

A number of residents had restraints in place in the form of bed-rails. There was

evidence from practice that appropriate risk assessments were completed in relation to bed rail use. A number of bedrails were padded to mitigate risk of injury to residents who had a tendency to occasionally be unsettled while in bed. Records were maintained and were complete to evidence bed rail disengagement schedules.

There was evidence to support satisfactory access by residents to appropriate allied health care professionals. Recommendations of referrals were implemented. Residents had adequate access to a GP of their choice.

A visitors' room was available for residents to meet their relatives in private

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
St Joseph's Nursing Home is a two storey building. Residents are accommodated over two floors, accessible by stairs and a mechanical lift. The centre's design and layout were generally suitable for its stated purpose. Residents' bedroom accommodation consisted of 16 single and two twin bedrooms. Five single rooms had en-suite shower, toilet and wash basin facilities. All other bedrooms have a hand-wash basin accessible to residents for their use. The inspector observed that bedroom facilities met the residents' needs. However one single bedroom did not have the minimum required usable floor space as recommended by the National Standards.

Communal accommodation for residents includes a dining room and two sitting rooms, one of which is also used as a visitors' room or a quiet area for residents to rest in. Residents had access to a spacious church. There was adequate access to washing facilities with a communal shower facility on both floors; residents also had access to a bath if they chose same. There were six communal toilets, three of which were wheelchair accessible. A wheelchair accessible toilet was located on each floor. Residents had adequate storage facilities for their clothing and personal belongings. A designated room on the ground floor was available for storage of hoists; a hoist was stored in an alcove on a corridor on the first floor. A risk assessment had been

completed to ensure its location did not hinder access or pose a risk of injury to vulnerable residents passing by same with concomitant controls to mitigate any risk in place.

There was adequate comfortable seating in the in residents' bedrooms and in the sitting room which was arranged in a way that was conducive to encouraging interaction between residents. Residents' independence was promoted by hand rails along corridors and grab support rails fitted in all toilets and showers. However, handrails were not in place along some areas of corridor on the first floor. Access to corridor with a ramped surface on the ground floor was adequately controlled on this inspection. An emergency call system was located in all parts of the centre including toilets and bathrooms. The temperature of the water was controlled and hand testing indicated the hot water did not pose a scald risk on the days of this inspection. Toilet facilities were provided within easy access of communal areas for residents' convenience.

The inspector observed some residents who were able to leave the centre going for a walk in the grounds. Although the centre was surrounded by mature gardens, there was no enclosed safe, accessible outdoor space which could be freely accessed by vulnerable residents. As the centre is located on an elevated site, the boundary of the surrounding surfaced areas to the back of the site was not protected and as such posed a risk to vulnerable residents and visitors who inadvertently accessed this area. This finding is also discussed in Outcome 8 of this report. The centre is located in an avenue off the road, which the inspector observed had recently been resurfaced addressing uneven surfaces of same.

The inspector found there was suitable and sufficient equipment such as hoists, pressure relieving mattresses and mobility aids available to meet residents' needs. The was a service contract in place which covered breakdown and repair for all beds, air mattresses and other equipment, used by residents. Inspectors reviewed the records of servicing to electric beds, chairs and hoists and observed them to be up to date. The Inspector found the centre to be clean, warm and well maintained internally. Residents expressed their satisfaction with the facilities provided in conversations with the inspector and in pre-inspection questionnaires completed.

Panel windows were fitted in the wall between a twin bedroom and a corridor and in a wall between a communal toilet and a corridor. These findings did not ensure residents privacy and dignity needs were met at all times and are referenced in an action plan in Outcome 16 of this report.

Judgment:
Non Compliant - Major

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
A complaints log was maintained in the centre and there was arrangements for complaints follow through. Verbal feedback from residents or resident's representatives was welcomed and arrangements were in place for recording same in line with regulatory requirements. While there was a low level of complaints in the centre and the inspector was told that most complaints were resolved at local level, there was evidence that verbal complaints were not consistently recorded. There was a written operational policy and procedure relating to the making, handling and investigation of complaints dated 20 April 2014. The procedure identified the nominated person to investigate a complainant and the appeals process. There were no active complaints under investigation on the days of inspection. Feedback in residents and relatives pre-inspection questionnaires reported satisfaction and a lack of a cause for complaint. The complaints policy was displayed and some residents were aware of the process and identified mainly the person in charge or the provider as the people whom they would communicate with if they had any issue of dissatisfaction.
There was a named advocate available if required by residents and a process was in place for auditing the complaint process.

Judgment:
Non Compliant - Minor

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:

A policy document informed practice in this area. There were no residents in receipt of end of life care on the days of inspection. Community palliative services were available to support residents at this stage of their lives and there was a referral process in place. End of life care staff training had commenced and further training was scheduled. A pain management tool was in place and was used to assess and monitor residents' pain where necessary. There was evidence that some staff had completed training on managing syringe pump medication administration. The inspector observed that residents' end of life wishes had been assertained and recorded.

Palliative care services were involved in the care of residents who were experiencing pain and a pain assessment tool was available to measure residents' pain levels as appropriate. Family members were facilitated to stay with residents who were in receipt of end of life care. Beverages and food was also made available to relatives who remained with ill residents the inspectors were told.Members of the congregation of religious sisters including the provider provide pastoral care to residents. Religious clergy were also available to residents and their families. Following the death of a resident, a removal service from the centre was arranged for them as a mark of respect which was attended by members the centre staff and residents who wished to be there. The centre's church was available to residents for their funeral service if they wished to use it.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
There was satisfactory evidence to support the finding that residents were provided with adequate fluid and dietary intake to meet their needs. The inspector was satisfied that each resident's individual nutritional and dietary needs were met and that they were offered a nutritious and varied diet that provided them with choice of a hot dish at each mealtime. Residents had access to fresh water in their bedrooms and communal areas. Staff were observed to engage in monitoring and encouraging residents to take fluids. There was a policy document available to support staff in all aspects of nutritional and hydration care including percutaneous endoscopic gastrostomy (PEG) feeding and subcutaneous fluid administration procedures. Residents' weights were monitored and those identified as at risk had evidence of monitoring and review by dietetic services.

The chef was aware of and accommodated residents with specific nutritional support needs, support plans and preferences. The chef had copies of the recommendations made by speech and language and dietetic therapy services. Care plans were in place to inform care of residents with nutrition and hydration needs which were satisfactorily linked to the content of daily progress notes.

The dining room is located at a central point in the building and was accessible for all residents. The lunchtime meal was observed by the Inspector. Three staff members were exclusively assisting residents with eating which was completed in a discreet and respectful way. Residents were offered a choice of two hot meals. A spicy option was available for the sisters who had worked abroad and had developed a taste for highly flavoured food the inspector was told. The dining room was spacious. Residents spoken with told the inspectors that they enjoyed the food provided in the centre. Staff training was scheduled and underway to inform staff on use of the nutrition assessment tool and fluid thickening procedures used.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
Inspectors were satisfied that residents were enabled to make choices about how they lived their lives in a way that reflected their individual preferences and diverse needs. The issue around residents being involved in a forum was previously identified in an action plan following the inspection of the centre in January 2014 as an area for improvement to ensure all residents had a forum at which they could participate in the running of the centre. The inspector observed on this inspection that both religious and lay residents' attended residents' committee meetings held on 21 April 2014, 19 June 2014 and 21st August 2014. The person in charge and residents spoke positively about this development and both embraced the opportunity this forum provided for sharing of information in respect to the running of the centre. A decision was made to have evening tea at 21:00hrs instead of 20:00hrs. The pharmacy service was also discussed and residents were informed of dates that the pharmacist was available in the centre to discuss their prescribed medications with them. Residents' significant other was also

welcomed to attend these meetings with the pharmacist.

There were many examples where residents were encouraged and facilitated to maintain their independence, for example residents who were assessed as able knew the code to the front door and were observed using it by the inspector to access same. Members of the local community visited some of the residents from the locality following their attendance at daily mass in the centres' church which enabled them to keep in touch with the community. Residents' privacy and dignity needs were met by staff at all times. Residents' bedroom and toilet doors were observed to be closed during episodes of personal care activities. However, glass panel windows were fitted in the wall between a twin bedroom and a corridor and in a wall between a communal toilet and a corridor. A privacy screen was not adequately fitted around one resident's bed in a twin room to ensure all her privacy needs were met and respected at all times. These findings did not ensure residents privacy and dignity needs were met at all times.
An aromatherapist attended the centre each Thursday and facilitated one to one sessions in the afternoon while residents were resting on their beds so that their usual routine was respected. The inspectors observed her working with the residents on one of the days of this inspection. Staff told the inspector that this therapy particularly benefited residents who had dementia care needs experiencing periods of restlessness.

There was a communication policy in use to inform communication strategies especially with residents who had illnesses
and medical conditions that resulted in them having communication deficits. Tools used included a communication board for a resident with hearing deficits and large print bingo cards for residents who had vision problems or reduced dexterity. The Inspector also observed that residents had a variety of local and national newspapers available to them in communal areas. The inspector observed some residents reading them and engaged in conversations with them on topics in the news which they were well informed about. The inspectors observed some residents watching the news on television and a radio was on in the background in the early part of one of the days of inspection.

The centre also had a mobile phone which residents could use if they wished to speak to relatives in private. There was a public telephone available on the ground for residents' to make and receive phone calls. Residents' confirmed that they had regular visitors and could choose were they would like to meet them.
There was a residents' communication board where items of interest to the residents were displayed.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
Residents could retain control over their personal possessions. There was a policy to inform management of residents' personal property and possessions which was up to date. Inspectors observed that there was adequate space provided for residents' clothing, personal property and possessions in their rooms. Residents also had access to a locked facility in their bedrooms for secure storage of personal possessions. Residents' clothing was observed to be clean and in good condition. Where possible residents were encouraged to choose the clothes they wore. Residents spoken with were highly complimentary of the laundry service provided. There were no complaints referencing dissatisfaction with management of residents' clothing.

There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents. The laundry was located outside the main centre premises. There was adequate worktop space for segregation of clean and used linen. An in line disinfection unit was in place which was serviced annually. Linen collection skips were available that appropriately segregated used linen in line with the national policy. The inspector spoke with the laundry staff member and found her to be well-informed on the laundry procedures. Clothes were neatly folded in drawers or hanging in wardrobes. All clothing was labelled to ensure correct identification of owner of each item of clothing and to prevent loss of any items. Records of residents clothing and personal possessions including items of personal furniture and assistive chairs was maintained with an inventory updated on a regular basis in respect of each resident which was reviewed by the inspector.

Judgment:
Compliant

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

Theme:
Workforce

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

Findings:
The staffing rota confirmed that there was a registered nurse on duty in the centre at all times. The inspector was informed by the person in charge that staffing levels were reviewed on an on-going basis to meet the changing needs of residents and were increased where necessary to meet the needs of residents who were assessed as requiring high levels of care. The inspector found evidence that the staff numbers and skill mix on the day of inspection were appropriate to meet the needs of residents accommodated in the centre. However, night time staffing levels required review as there was evidence from the record of resident falls for the period March to July 2014.referencing 90% of falls occurring between 00.30hrs and 05.40hrs.

The inspectors were provided with copies of the staff rotas and staff files as requested which were reviewed to assess compliance with the legislation in each case. The duty rotas given to the inspectors for review referenced the full name of all staff working in the centre and hours of duty worked as required. The staffing rota reviewed indicated that the person in charge position was staffed five days per week. The person in charge was also supported by a deputy, staff nurses, carers, catering, housekeeping and laundry staff.

There was evidence that staff had undertaken training on a range of health-care topics relevant to their roles. All mandatory staff training requirements were met. Staff practices observed were in line with contemporary evidence based practice and there was evidence of satisfactory supervision of staff appropriate to their roles.

Residents spoken with spoke positively in relation to staff competence and skill in meeting their needs. Staff spoken with were knowledgeable about the residents' needs.

There was a recruitment policy in place and all staff files reviewed contained the required documentation. A record of the current registration details of all staff nurses working in the centre was maintained and was up to date.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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Regulation Directorate
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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	St Joseph's Nursing Home
Centre ID:	OSV-0000169
Date of inspection:	01/09/2014
Date of response:	06/03/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A revised declaration of fire safety was required by the Authority on completion of fire safety works in progress as required by Monaghan fire services.

Action Required:
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation

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

prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015

Please state the actions you have taken or are planning to take:
An updated fire certificate has been forwarded to the Authority.

Proposed Timescale: 06/03/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all information analysed informed improvement. Concomitant quality improvement plans were not consistently developed as part of the quality improvement process to include details of the actions to be taken, completion timescales and delegation of a designated person with responsibility for completion to ensure there was timely resolution of deficits identified from analysis of audit data collated.

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

Please state the actions you have taken or are planning to take:
A robust system of audits are in place and quality improvement action plans are now included at the end of each audit.
A report on the Quality and Safety of Care of Residents in St. Joseph's Nursing Home has been compiled. This report includes concomitant quality improvement plans for 2015 which will guide and inform improvements to care and quality.
This report is made available for residents to read and review.

Proposed Timescale: 06/03/2015

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not include cause of death in respect of some residents referenced.

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

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

The directory of residents now includes cause of death, as absent on one resident.

Proposed Timescale: 05/12/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Commentary records of fire drills held in the centre were not complete in some entries.

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

Please state the actions you have taken or are planning to take:
Records are maintained of all fire drills and evacuations carried out. All recent fire drills and evacuations have more detailed commentary records which clearly show full or horizontal evacuation (from one zone to another), exact length of time and any difficulty encountered.

Proposed Timescale: 06/03/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre's insurance details forwarded did not clearly reference cover against loss or damage to a resident's property as required.

Action Required:
Under Regulation 22(2) you are required to: Insure against other risks, including loss or damage to a resident’s property and advise the resident accordingly.

Please state the actions you have taken or are planning to take:
The insurance details have been checked with the insurance broker and do include and state cover against loss/damage to a resident’s property.

Proposed Timescale: 06/03/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While the risk register had been reviewed there were a number of risks identified during

the inspection by the Authority that were not recorded in the hazard identification documentation. These hazards included the following:
- absence of handrails on some corridors on the first floor,
- absence of footpaths along the avenue
- a footpath through the front garden, the surface of which was in a hazardous condition
- inadequately secured boundary edges of some hard surfaced areas located at the back and side of the centre.

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

Please state the actions you have taken or are planning to take:
The Risk Register has been amended to include all of the above.

Proposed Timescale: 05/12/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were a number of risks identified during the inspection by the Authority that were not recorded in the hazard identification documentation and as such did not have the measures and actions to control risk documented. These hazards included the following:
- absence of handrails on some corridors on the first floor,
- absence of footpaths along the avenue
- a footpath through the front garden, the surface of which was in a hazardous condition
- inadequately secured boundary edges of some hard surfaced areas located at the back and side of the centre.

Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
1. Handrails have been placed on all corridors on the first floor.

2. Signage has been put in place along the avenue to alert drivers to the possibility of pedestrian use; however a footpath along the length of the avenue has not yet been commissioned.

3. A secure gate has been placed at the entrance to the footpath, preventing access to the pathway beyond.

4. Access to the back and side of the nursing home has been restricted by the erection of a fence which limits entry. A "No Entry" sign is also in place.
Proposed Timescale: Completed apart from the footpath which has not yet been commissioned.

Proposed Timescale: 06/03/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no sink fitted in the medication storage area

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

Please state the actions you have taken or are planning to take:
The medication storage area is a small ante area within the nurse's office. The nurse's office contains a sink and is within nine foot of the medication storage area.

The medication storage area contains the medication trolley and storage space for clinical items, including medications. The is no available space to include another sink.

Proposed Timescale: 05/12/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was some commentary available, this required improvement to reference all aspects of the fire drills completed. In addition, it was not clear if evacuation was from one zone to another or outside the building.

Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Records are maintained of all fire drills and evacuations carried out.
All recent fire drills and evacuations have more detailed commentary records which clearly show full evacuation to outside the building or horizontal evacuation (from one

zone to another), exact length of time and any difficulty encountered.

Proposed Timescale: 06/03/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Additional information to inform staff with medication preparation and administration was documented by the pharmacist, however, there was no reference document available to staff to advise of potential interactions of medication mixing or altered effects when administered in crushed format.

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

Please state the actions you have taken or are planning to take:
Each resident who receives medications in a crushed format has an individual pharmacy review and assessment, focusing on the administration of those specific medications prescribed for the resident. This information is contained both in the resident's care plan and attached to the resident's medication administration sheets.
The medication administration sheets also contain detailed administration instructions.
Also the nurses have access to "NEEMMC Guidelines for Tablet Crushing", a guidance document located on the medication trolley

Proposed Timescale: 05/12/2014

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One single bedroom did not have the minimum required usable floor space as recommended by the National Standards.

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

Please state the actions you have taken or are planning to take:
A large built-in wardrobe has been removed from this bedroom, creating extra usable

floor space. A free standing wardrobe is now in place.

Proposed Timescale: 05/12/2014

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Handrails were not in place along some areas of corridor on the first floor.

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

Please state the actions you have taken or are planning to take:
Additional handrails will be placed along the first floor corridor where required.

Proposed Timescale: 28/02/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no enclosed safe, accessible outdoor space which could be freely accessed by vulnerable residents. As the centre is located on an elevated site, the boundary of the surrounding surfaced areas to the back of of the site was not surely protected and as such posed a risk to vulnerable residents and visitors who inadvertently accessed this area.

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

Please state the actions you have taken or are planning to take:
There is a safe and easily accessible outdoor terraced area, located off the main sitting room. This is accessed via a door from the sitting room. It is an enclosed area with a key-coded exit gate which allows vulnerable residents to safely go outside if they choose to.
Vulnerable residents are always accompanied outside by a staff member.

Access to the back and the side of the nursing home has been restricted by the erection of a fence which limits entry. A "No Entry" sign is in place.

Proposed Timescale: 06/03/2015

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Verbal complaints were not consistently recorded

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

Please state the actions you have taken or are planning to take:
All verbal complaints will be recorded, actioned and signed off.
All issues brought forward by the Resident's Association are promptly addressed and recorded.

Proposed Timescale: 06/03/2015

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:
Glass panel windows were fitted in the wall between a twin bedroom and a corridor and in a wall between a communal toilet and a corridor. These findings did not ensure residents privacy and dignity needs were met at all times.

A privacy screen was not adequately fitted around one resident's bed in a twin room to ensure all her privacy needs were met and respected at all times.

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

Please state the actions you have taken or are planning to take:
The glass panel has been filled in. Plaster board has now been fitted.
The privacy screen has been replaced to ensure the resident's privacy needs are met.

Proposed Timescale: 05/12/2014

Outcome 18: Suitable Staffing
Theme: Workforce **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Night time staffing levels required review as there was evidence from the record of resident falls for the period March to July 2014.referencing 90% of falls occurring between 00.30hrs and 05.40hrs. **Action Required:** Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre. **Please state the actions you have taken or are planning to take:** The previous two audits, for a six month period ending January 2015, both show a reduction in the number of night time falls. The last audit for November & December 2014 and January 2015, actually details a vast improvement, with a total number of falls for the three month period totalling five, with three falls (60%) occurring between 20.00 & 08.00 hours. Residents who are at risk of falling are clearly identified in staff handovers, heave regular medication reviews and are closely observed. It is also important to consider that one resident accounted for the vast majority of all our falls, and this resident is no longer residing here. However if the number of falls occurring during night time should continue, then an extra member of staff will be roistered to night-duty.
Proposed Timescale: 06/03/2015