

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Clarehaven Home
Centre ID:	OSV-0000511
Centre address:	St. Canice's Road, Glasnevin, Dublin 11.
Telephone number:	01 704 4430
Email address:	mary.flanagan1@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Michelle Forde
Lead inspector:	Leone Ewings
Support inspector(s):	Jim Kee
Type of inspection	Announced
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	2

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:
10 February 2015 09:00	10 February 2015 18:00
11 February 2015 09:30	11 February 2015 17:30

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 announced inspection and was the sixth inspection of the centre. The inspection took place over two days and was for the purpose of monitoring and informing an application to renew the registration. The centre was purpose built in the 1970's and is one of three services which make up Claremont Residential and Community Services. The designated centre provides long and short term care for older persons and the provider had applied for registration for 25 places. As per the statement of purpose 21 beds are for long term care and four are for short term respite admissions. This report sets out the findings of the inspection and areas identified for improvements.

The inspectors found that overall the provider met some of the requirements of the

Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. All documents submitted by the provider for the purposes of application to register were found to be satisfactory. The management team had fully addressed the non-compliances further to the inspection completed on 15 May 2013.

The management team in place worked well together to ensure that overall there was a robust governance structure in place. Residents and relatives confirmed their satisfaction through the questionnaires completed and returned prior to the inspection. Changes to the provider nominee had taken place since the last inspection and the Authority had been provided with full and complete information on the new provider nominee. The provider nominee is based at the Local Health Office and is a general manager, and she has demonstrated her fitness through the notifications process and contact with the Authority since the time of the change.

The person in charge has not changed since the time of initial registration by the Authority. The person in charge was found to be a fit person at the time of the initial registration application and is a shared role between three designated centres in the Claremont Services. The person in charge was on leave at the time of the inspection. Day to day management responsibilities are with the clinical nurse manager who works closely with the person in charge, and is the nominated person in the absence of the person in charge. She is supported in her role by one other clinical nurse manager, nursing and health care assistants, allied health professionals, administrative, catering, maintenance, household and laundry staff and management team.

The inspectors found that the health needs of residents were met to a very good standard. Residents had access to medical care, to a full range of other allied health services and the nursing care provided was of a high standard. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day with meaningful activities available.

Residents were consulted about the operation of the centre and there was an active residents' and relatives meeting. Residents and relatives knew the management team and who to contact should there be any dissatisfaction with service provision. The collective feedback from residents was one of satisfaction with the service and care provided, particularly the personal attention given to residents and visiting relatives.

The provider and person in charge promoted the safety and quality of life of residents. Staff had an in-depth knowledge of residents and their individual needs. Recruitment practices met the requirements of the Regulations.

A risk management process was in place for all areas of the centre, some improvements were required relating to the frequency of incidents out of hours. Staff had received training and were knowledgeable about the prevention and detection of elder abuse, safeguarding and other relevant areas. A notification had been received relating to an allegation of abuse and had been partially investigated by

management, further review of the incident was required to include outcomes and recommendations for practice.

Areas for improvement were identified and the centre was non-compliant in 9 of the 18 outcomes inspected against; improvements requirement include a major non-compliance relating to staffing at the centre out of hours and safeguarding. Moderate non-compliances relate to governance and management, the premises, risk management and improvements in the care planning process for health and social care needs. The remaining three outcomes were substantially compliant and these areas for improvement are discussed further in the report and are included in the Action Plan at the end of this report.

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):

No actions were required from the previous inspection.

Findings:

The inspector reviewed the statement of purpose submitted with application to register which was a detailed document, informative and easy to follow and clear in presentation. The statement of purpose contained most of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

However, some information had not been included such as :

- conditions of registration currently in place
- arrangements in place for laundry for residents in receipt of Nursing Homes Support Scheme
- accurate staffing complement to reflect current rosters
- recent changes in number of beds for long term care and short term respite provision.

Judgment:

Substantially 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:

Relatives and residents confirmed that they could easily identify with the management team; the two clinical nurse managers worked opposite each other and were visible at the centre on a daily basis. The person in charge was not on duty at the time of this inspection, and the clinical nurse manager was covering her leave with support from the assistant director of nursing. The inspector found that there were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

There was a defined management structure that identifies the lines of authority and accountability. The person in charge, who was not based full time in this designated centre, was found to work closely with her deputy manager to undertake the responsibilities of person in charge which is currently shared between three designated centres. However, the inspector discussed with the provider that an additional clinical nurse manager be named as a person participating in management in order to fully reflect the actual arrangements in place.

Management meetings were established and reviewed aspects of service provision, staffing, health and safety, training, complaints and any other relevant issues which were seen to be actioned. Some improvements were required in management systems to ensure that the service provided continues to be safe, appropriate to residents' needs, consistent and effectively monitored, particularly around record keeping and management and staffing review. Evidence of audit and review of practice following audit was not fully evident in some areas for example, falls and incident management and the necessary follow up to ensure resident safety and prevent further incidents.

There were some established system in place to review and monitor the quality and safety of care and the quality of life of residents on a three monthly basis. Improvements were brought about as a result of the learning from audit completed and feedback from residents and relatives. There was evidence of consultation with residents and their representatives and actively working on any feedback received from residents and relatives. For example, the resident satisfaction survey shown to the inspector. However, an annual report on quality and safety in line with legislative requirements was not available at the time of the inspection. The inspector was informed that formal arrangements were in place to establish the content of such a report to include all the information and data collected to demonstrate compliance.

Outstanding documentation relating to compliance with fire and planning legislation was not received prior to this registration inspection, these documents are required to be submitted to the Authority before a recommendation for registration can be made by the inspector.

Judgment:

Non Compliant - Moderate

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The resident's guide was detailed and contained most of the relevant information outlining service provision. Additionally a resident newsletter, notice boards and information leaflets were available for residents and relatives. Residents attended their own meetings and had access to advocacy services who met with residents regularly. The inspectors observed a meeting being held in the library on the day of the inspection and met and discussed their roles with two people present who held meetings with residents. The inspectors also met with a resident who had moved to the service recently and he was well informed about it, and had an opportunity to visit prior to the move.

The inspector reviewed in detail a sample of four contracts of care. Each resident had a detailed contract of care dealing with the care and welfare of the resident at the centre which provided detail on the services to be provided and associated fees. Written contracts were agreed on admission and were in place for all long term residents. Fees were clearly stated, the provider was asked to clarify wording of the contract in relation to the provision of laundry services for those residents admitted under the agreements made through the Nursing Homes Support Scheme (NHSS).

Judgment:

Substantially Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge had not changed since the time of the initial application for

registration. Inspectors had determined the fitness and suitability of the person in charge at that time. The inspector was satisfied that the person in charge and deputy manager at the centre were suitably qualified and experienced to fulfil their roles, and both had completed satisfactory fit persons interviews with the Authority. The person in charge was not based day to day at the service, but she was fully supported by a clinical nurse manager 2. As discussed under Outcome 2 formal details of the clinical nurse manager 1 day to day involvements require submission to the Authority as a person participating in management.

The person in charge reported into the provider nominee, a general manager based in the local health office. They meet on a formal basis regularly. Other supports included practice development, human resources, catering and administrative staff.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The non-compliance further to the monitoring event of 15 May 2013 was found to have been addressed and the residents' care plans were now inclusive of actual care provided and plans in place further to risk assessments completed. However, further to a review of a sample of documentation some improvements were identified and communicated to the clinical nurse manager. For example; some property records viewed were unsigned and not kept up to date, and resident care plans being reviewed by night staff with no evidence of residents or relatives involvements in the review process (as described in Outcome 11).

Overall the records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Some of the records reviewed were maintained to a high standard for example; follow up from medication management issues identified by the provider. However, a major

non-compliance was discussed relating to the storage of archived resident nursing and medical records in an inappropriate storage room, which was unlocked and readily accessible by staff to obtain household items. The clinical nurse manager advised she would act to address this matter and find appropriate alternative storage on site.

Staff easily retrieved all relevant information requested by the inspector at the time of the inspection and were knowledgeable about residents care needs. All staff had received training and guidance on maintaining standards of clinical documentation, and established system of audit of documentation was in place known as 'nursing metrics'. Overall nursing and clinical records were maintained to a good standard and records reviewed were found to be person centred and accurate.

The provider submitted evidence that the designated centre was adequately insured against accidents or injury to residents, staff and visitors.

The inspector found that the risk register had been completed and had up to date risk assessments and detailed measures to mitigate any identified risks.

The designated centre had all of the written operational policies implemented as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013.

Judgment:

Non Compliant - Major

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

At the time of the inspection the person in charge had not been absent for more than 28 days which required notification to the Authority. The inspector formed the view that there were suitable arrangements in place for the management of the centre in the absence of the person in charge.

The clinical nurse manager took charge of the centre when the person in charge was absent or on leave, she was supported by an assistant director of nursing based at a nearby designated centre. She confirmed that she had adequate supports from the person in charge, as outlined in Outcome 2 details of a further clinical nurse manager should be submitted to reflect the actual management of the centre.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Measures were in place to protect residents from being harmed or suffering any form of abuse. Appropriate action was seen to be taken following an incident notified to the Authority. However, some improvements were required relating to documentation of actions taken following an allegation made, and gaps relating to the completion of the investigation and report and there were no conclusions, or further recommendations for practice included.

A robust policy and procedures was in place for, the prevention, detection and response to any allegation of abuse. It included guidance for staff in the event the person in charge was named in any allegations of abuse and included contact details for the senior social worker adult protection and advocacy service.

Residents spoken with told the inspectors they felt safe in the centre. The inspector saw that all main entry/exit doors were kept secure and a keypad was in place. There was a visitor's sign in book at the main entrance. The door to the rear garden was fully accessible to residents and they were observed accessing this space throughout the inspection.

The inspectors saw evidence that all staff had up-to-date training in relation to the prevention, detection and response to abuse. Staff spoken with had a good, clear understanding of what constitutes abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. Their knowledge reflected that outlined in the updated policy and procedure.

There were systems in place to safeguard residents' money and facilitate access for comforts and outings. There was a policy on, and procedures in place, for managing behaviour that may be challenging. Efforts had been made to identify 'behaviours of concern' and alleviate the underlying causes and provide appropriate supports and meaningful activity where required. For example, a resident who spent a lot of time

alone in their bedroom, had regular access to a complimentary therapist who provided individually assessed therapy, which was documented as being relaxing for the resident.

Prior to the inspection the Authority had received information regarding allegations of abuse made by a resident whilst an in patient in an acute service. Further to the centre being notified of the allegations the appropriate notification of the allegation was made to the Authority and an investigation commenced. A discussion was held with the clinical nurse manager relating the action taken and a request was made to review the relevant documentation. The measures taken communicated by the clinical nurse manger were found to be appropriate to manage and mitigate any risks identified and the allegation was found not to be founded. However, aspects of the original allegation had not been considered as part of the overall investigation, and the standard of reporting and documentation required improvement to fully reflect the actions taken by the relevant staff involved.

Judgment:

Non Compliant - Major

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

Theme:

Safe care and support

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

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

Findings:

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

The inspector noted that there was an up to date health and safety statement in place. The risk register was also kept up to date and internally the building was found to be kept relatively hazard free. Environmental risk was addressed with health and safety policies implemented which included risk assessments on such areas as environmental hazards. A risk management policy was in place and met the requirements of the Regulations.

Fire precautions were prominently displayed throughout the centre. Service records showed that the emergency lighting, fire alarm system and fire fighting equipment were serviced and fully maintained. The inspector noted that the fire panels were operating correctly, and the means of escape and exits, which had daily checks, were unobstructed. The inspectors noted that some roof tiles became dislodged and were

found broken outside external fire escape doors. All staff had attended training and those spoken with were knowledgeable of the procedure to follow in the event of a fire. Regular fire drills had taken place and the fire alarm was tested and serviced every three months. An emergency evacuation plan was in place which provided clear guidance to staff, which identified what to do in the event of fire, flood, loss of power or heat or any other possible emergency.

The emergency plan outlined the specific support requirements for residents in case of emergency. An emergency fire evacuation blanket was in place on each bed and checks made on a regular basis on this for any damage.

A review of the training records evidenced that all staff had attended mandatory training in patient moving and handling. Staff confirmed that they had up to date knowledge on the use of moving and handling equipment. There was sufficient equipment provided for the safe moving and handling of residents such as portable hoists and other moving and handling aids to mobility. The service records were viewed which confirmed they had been serviced as require. Many residents were independently mobile and moved in and out of the centre with no assistance. Staff were observed supporting residents to mobilise in a safe and consistent fashion, in accordance with individual moving and handling care plans.

Falls and incidents reported were reviewed by the clinical nurse manager and on each occasion satisfactory measures were in place to mitigate the risks associated with recorded individual incidents. However, the current audit process in place was not sufficiently robust to evaluate that many of the accidents and incidents were taking place out of hours, in the early evening and night time, when staffing levels were reduced.

For example, two incidents of challenging behaviour which took place were not sufficiently reviewed from with regard to supervision and staffing requirements by the person in charge. The provider was requested to review this matter in line with findings of Outcome 18 to mitigate and further risks associated with having two staff on duty overnight to provide care for the residents some of whom were noted in the documentation to wander in the centre at night.

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):

No actions were required from the previous inspection.

Findings:

The inspectors were satisfied that each resident was protected by the designated centre's policies and procedures for medication management and there was evidence of good practice. There was a medication policy which guided practice and administration practices were observed to be of a very high standard. Nursing staff were familiar with the arrangements around accepting delivery and appropriate storage requirements were fully implemented. One area for improvement identified was around the storage and use of food supplements on the trolley and general storage arrangements for stock of food supplements at the centre.

The inspectors viewed completed prescription and administration records and saw that they were in line with best practice guidelines. Written evidence was available that three-monthly reviews were carried out. The pharmacist was also involved in medication safety and was available if required in the centre. The minutes of the medication review meeting were reviewed by the inspector and learning from the two other designated centres managed by the provider was shared. Competency assessments were also completed on induction with new nursing staff and on an ongoing basis by the person in charge or her deputy.

The inspector observed medication administration and found that medication was seen to be administered in line with the policy and best practice. Medication was stored in locked cupboards in a designated clinical storage room, and designated staff only had access to keys for this purpose.

Medications that required strict control measures were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of all controlled drugs. The inspectors confirmed that the stock balance was checked and signed by two nurses at the change of each shift. The inspector observed administration of this medication to a resident and found practice was safe. There were appropriate procedures for the handling and disposal of unused and out of date medicines. The inspectors noted that two items of medication stored on the trolley did not have the date of opening recorded on these items.

Medication audits were completed by the person in charge or her deputy to identify areas for improvement and there was documentary evidence to support this. Medication errors were reviewed by the person in charge and the clinical governance committee and systems were in place to minimise the risk of future incidents. Findings were discussed at nurses meetings, and there was clear evidence of learning from colleagues and other nearby centres on the campus.

All staff nurses involved in the administration of medications had undertaken medication management training, and practice was audited and reviewed by the practice development co-ordinator and learning communicated to improve practices. Systems in place were robust and evidenced by checks and audits completed by staff on receipt of medication, and near miss reported incidents which had detected a number of errors detected during late 2014. Meetings were held with the pharmacy provider to identify the cause of these errors and prevent further occurrences.

Judgment:

Substantially Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Clear and concise records of all incidents occurring in the centre were maintained and made available for review.

The inspector found that all notifiable incidents had been notified to the Chief Inspector within three working days. Quarterly reports had been provided to the authority to notify the Chief Inspector. The inspector requested an update on a notification made relating to a death, and the clinical nurse manager confirmed that this would be forwarded when the information was available.

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):

No actions were required from the previous inspection.

Findings:

The inspectors were satisfied that resident's healthcare and social care needs were met to a good standard and the arrangements to meet residents needs were set out in a care plan with the involvement of the resident or relatives. Improvements were required relating to the documentation of care and review process for care planning in place to

fully involve residents and their representatives (where appropriate), and fully reflect the changing care needs.

The feedback received from residents relating to available meaningful activities was found to be good. Respondents to the questionnaires named good activities such as baking, games, exercises, and spiritual activities at the centre. Some external activity facilitators also contributed and were in place and activity such as pet therapy and inputs from the clinical nurse specialist in complimentary therapy who visited regularly.

All residents had access to medical care, the in house medical officer provided cover for residents on short respite stays, and each long term resident had their own general practitioner (GP) and full access to the out of hours services. Efforts were confirmed to ensure residents when admitted to the service could retain their own GP to ensure and promote continuity of care. A full range of other services available on referral including occupational therapy, speech and language therapy (SALT), dietetic services could be accessed. Chiropody, dental and optical services were also provided, and an in-house ear care service which residents could access which provided audiology assessment. The inspector reviewed residents' records and found that residents had been referred to services and records and results of appointments were written up in the residents' notes in a timely manner. The allied health professionals documented the assessments and reviews completed which in turn informed the nursing care plans.

The inspectors saw good examples of pre-admission assessments in place and nursing risk assessments completed for each resident. Nursing assessments; care plans and additional clinical risk assessments were found to be carried out and completed for each resident. Daily notes were being recorded in line with professional guidelines, and in a person centred manner and adequately described health and social care needs.

The care plans reviewed by the inspectors contained the required information to guide the care for residents, and were updated to reflect the residents changing care needs. However, some improvements were required relating to the manner and mechanisms of how residents and/or relatives were involved in the development of their care plans. Some care plan reviews and evaluation were documented and be written up out of hours by nursing staff, and not contemporaneously following a formal review of care as required by the legislation.

There was a policy in place on falls prevention to guide staff. The inspector read the care plans of residents who had fallen and saw that risk assessments were undertaken and a care plan was devised and/or reviewed. Observation during the inspection hours confirmed that there was good supervision of residents in communal areas and adequate staffing levels on the day of the inspection to ensure resident safety was maintained. Neurological observations were completed when residents sustained an unwitnessed fall. Records of clinical incidents which were found to be fully completed.

Further improvements as outlined in Outcome 8 were required relating to audit which took place particularly relating to staffing and supervision out of hours. The evidence obtained during this inspection was that care delivery was in line with evidence based practice with good outcomes were in place for residents, with a respect to each residents right to refuse treatments offered.

The inspectors found that there was an emphasis on minimising the use of restraint, and implementing alternatives. Training had been provided to staff on the use of bed rails and around other restrictive practices. Risk assessments were completed and kept updated for the use of bed rails.

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

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The inspector was satisfied that the provider had fully addressed the non-compliance from the inspection report dated 15 May 2013. A discussion was held with the provider at feedback, and a request to provide a plan relating to improvements required to address non-compliances relating to the premises in order to meet the collective and individual needs of each resident; and the requirement for the provider to ensure the premises becomes fully complaint by 1 July 2015 in line with the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Issues around car parking, and repairs required to external wooden cladding and plastic guttering had been addressed. However, since the time of the last inspection there were three areas of damage to the centres' roof, which involved leaks and water damage, to the entrance hall, dining area and corridor which have not been addressed.

The centre has 17 single rooms with hand washing sinks, and 4 twin bedrooms with shared en-suite between two rooms. Sixteen of the single bedrooms were of minimum size, and mostly accommodated residents who were mobile or required the assistance of one staff member only. Residents with maximum dependency were accommodated in larger rooms where assistive devices could safely manage their assessed moving and handling needs.

The general storage requirements needed further review relating to chemical and household product storage. The premises required obvious re-decorating, and some residents and relatives commented on the need to "update" premises.

The centre is a purpose built centre during the 1970's with all accommodation on the ground floor level for 25 people. The centre was constructed to provide long term accommodation to a larger number of residents. However, improvements have taken place over the last number of years which have reduced the number of residents to 25 people and provide more private accommodation. All areas were found to be clean, warm and hygienic.

A safe secure landscaped garden was located on the premises and was fully accessible to residents. The inspectors observed the centre to be divided into two distinct areas Green haven and Blue haven.

Facilities include a large communal sitting room with dining space. Kitchen and storage areas, library, visitor's room. Two assisted shower rooms and one assisted bathroom, toilets, complimentary therapy room, storage rooms, clinical room, activities room and adjoining kitchen area. There were privacy locks found on all of the toilets, showers and bathrooms visited.

Waste was disposed of in line with best practice including clinical waste. No residents had specific requirements relating to infection prevention and control. The kitchen was well organised, hygienic with suitable and appropriate storage. Food was prepared at a nearby designated centre and transferred via the back gate to the kitchen, at mealtimes.

The laundry facility for personal items of clothing was located separate to the centre on site, ironing also took place at the nearby designated centre and clean clothing was returned to each resident.

Parking is available to the front of the building with additional parking on campus which is shared with day care provision and additional designated centres. The inspectors noted that the front driveway was uneven in places and some potholes were evident, the pathways were paved for residents to exit and enter the premises.

The environment was reasonably maintained throughout, and there was evidence of decorative works in the living and dining areas. However, further areas for painting and upgrading were identified associated with normal wear and tear. Improvements were required in some residents' bedrooms, the assisted bathroom, where the bath was found to be not working and required maintenance. The communal areas such as the day/dining room were furnished comfortably.

Most equipment provided allowed for independent living and grab rails and hand rails were evident and appropriate to the dependency of the residents. A grab rail was awaiting repair in the assisted bathroom also according to the clinical nurse manager. A call bell was not available to residents using the smoking room, to contact staff if required, it was located in an area adjacent to the dining and living accommodation and was well ventilated.

The centre has 25 beds providing services to persons predominantly over the age of 65 years requiring long-term care, four beds are currently allocated for respite admissions. Admissions take place with regard to the admissions policy and an individual assessment takes place. The admission criteria is clearly outlined in the statement of purpose and function and has changed recently to include 21 long term residents and four respite beds.

Judgment:

Non Compliant - Moderate

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:

The inspectors were satisfied that the complaints policy was fully implemented at the time of the inspection. There was a written complaint's procedure on display. Residents, relatives and staff were aware of the complaint's policy and procedure, and confirmed their own understanding of the process in questionnaires and verbally with inspectors. The person in charge was the complaint's officer and dealt with all complaints. In practice issues were recorded at local level and reviewed by the clinical nurse manager and with the person in charge when they met.

The inspectors reviewed the records and there had been no written complaint since the time of the last inspection. An independent appeals process was clearly outlined in the complaint's policy and residents and relatives were aware of their right to complain.

Information leaflets were available in the entrance hall for residents or relatives to review

Judgment:

Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents received a high standard of end-of-life care which was person centred and respected the values and preferences of the individual and resulted in positive outcomes for residents. This centre had completed a thematic end of life inspection by the Authority during 2014, which had required self assessment and was found to be in full compliance with end-of-life-care.

There was a detailed policy on end of life care which was centre specific and provided guidance to staff. Staff members were knowledgeable about this policy. The clinical nurse managers informed the inspector that care plans were in place and reviewed to ensure they met the changing needs of residents. The inspectors confirmed this was the case further to a review of a sample of assessments and care plans. Care plans were found to reference the religious needs, social and spiritual needs of the resident as well as preferences as to the place of death and funeral arrangements as appropriate. Regular family meetings were held and were attended by the GP and nursing staff as appropriate.

The details of any preferences of the resident concerning future health care needs had been discussed with the GP and documented. Seventeen of the residents resided in single rooms, and access to a single room for those residents in a twin room could be facilitated should the need arise according to the person in charge. At the time of the inspection a resident was identified as requiring end-of-life comfort care and the inspectors found that staff worked together to provide respectful and dignified care, and all entering the centre were aware as the symbol to indicate this fact was displayed at the front door.

Refreshments and a visitor's room with reclining relaxing chairs were available for any visiting family members who wished to stay with their loved one. There was evidence that the centre also received support from the local palliative care team when required. The service was accessible upon referral by the GP. Senior staff at the service had completed post graduate qualifications in palliative care nursing and were knowledgeable and shared their knowledge with other staff.

Residents, spoken to by the inspectors, stated that their religious and spiritual needs were respected and supported and that their wishes regarding their preferences and choices at their end of life had been discussed with them or their family. This was

confirmed by inspectors further to review of residents' records. Mass took place weekly, in the day room, and the centre was located very close to the local community religious facilities.

Residents and visitors were informed sensitively when there was a death in the centre. Residents were informed in person and allowed to pay their respects if they wished to do so. Residents were invited to attend funeral services and staff also attended to say prayers and say goodbyes.

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:

All lines of enquiry were followed during the last thematic inspection in April 2014 relating to a detailed review of this outcome and the provider was found to be in full compliance. Food and drinks were provided in quantities adequate for residents needs, and available on a regular and as required basis. Menus were reviewed and food options gave choice and variety, and were based on feedback from residents and inputs and review from the dietician. The inspectors confirmed full compliance on this occasion relating to this outcome, and there were no areas for improvement identified.

The main dining space was well furnished, and had been re-decorated since the time of the last inspection, and the catering equipment previously on display has been moved to the kitchen space to allow for more room and a more homely dining experience. The area was well bright, hygienic and well ventilated. The area formed part of the main day space and was fully accessible with space to move wheelchairs and mobility aids between the tables.

The inspector observed mealtimes at the centre and found that food was attractively presented and a social occasion. Residents were offered a choice of food at each meal time and individual preferences were readily accommodated. The nursing and care staff monitored and supervised the meal times closely. Residents' who required their food to be modified, for example pureed, were served this food in individual portions and had the same choices of food at the main meal which was presently separately on the plate.

Regular drinks were provided during the day and with meals. For example, water, juices, diluted juices and sugar free carbonated drinks. Portion sizes were appropriate and all residents expressed satisfaction with their meals to the inspector on the day of the inspection.

The inspectors spent time in the dining room and visited residents who also chose to eat their meals in their bedrooms and found that the dining experience was dignified, pleasant and relaxed for all residents. The inspector observed staff seated beside residents assisting them with a meal and assisting one resident at a time with their meal. The meal time provided opportunity for social interaction between staff, residents and relatives. Residents confirmed their satisfaction with meals provided and options available on a daily basis.

Relevant information pertinent to the meal time was in place and was reviewed by the catering manager and person in charge. The information was reflective of an in depth knowledge of residents dietary needs, likes and dislikes were fully documented. Snacks were provided at any time as requested, a variety of snacks, such as yoghurt, scones, crackers and fruit were available.

The Inspector found that weight records showed that residents' weights were checked monthly or more regularly if required. Nutrition assessments were used to identify residents at risk and were also repeated on a regular basis. Records also showed that some residents had been referred for and received dietetic and speech and language (SALT) and/or dietetic review. The treatment plans for residents was recorded in the residents' records.

Medication records showed that supplements were prescribed by the dietician attached to the service and administered appropriately by nursing staff. However, catering staff provided fortified meals as a first choice as individually required. Communication was noted to be of a high standard between catering and dietetics, and changing requirements fully documented in a timely manner.

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):

No actions were required from the previous inspection.

Findings:

The inspectors were satisfied that all staff treated residents with dignity and respect, with regard to each individual's privacy and dignity and that strong emphasis was placed on these values by management and all staff interacting with residents. The resident survey completed by 16 residents confirmed a high level of satisfaction with how rights were upheld, and how care was offered with dignity and levels of consultation about change. For example, changes in the layout and decor in the dining room had taken place since the last inspection and residents had been consulted regarding their opinion about proposed changes.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. The inspector observed staff interacting with residents in a friendly and courteous manner. There was an open visiting policy and contact with family members was encouraged and facilitated. A private visitor's room was available, and refreshments were also available.

Residents' meetings took place within the centre and the inspector read the last minutes. Residents told the inspector they had opportunities to discuss issues as they arose with the person in charge, clinical nurse manager or any staff member. The clinical nurse manager told the inspectors that any issues raised by residents were addressed at local level.

Residents had access to advocacy services, two staff from an advocacy service were visiting to conduct a residents meeting, met with residents regularly and any issues raised were raised with the person in charge or staff on duty, to follow up on.

Relatives and residents said if they had any query it was addressed immediately. They also said they were kept up to date with any changes in health or social care. Evidence of family meetings and communication prior to any admission were evidenced in the documentation and through the pre-inspection questionnaires.

The inspector found that most residents said they had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them. They chose when to go to bed and the times they got up each morning.

The inspector noted that televisions had been provided in residents' bedrooms. Residents had access to newspapers daily. Access to the internet and broadband was facilitated for residents.

Judgment:

Compliant

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents admitted under the Nursing Homes Support Scheme had laundry services included in the overall fee and this was outlined in the contract of care, and resident's guide. Residents could have their laundry attended to within the centre, although in practice many residents' families take personal laundry home. Residents and relatives expressed satisfaction and were complimentary about the laundry service provided.

The inspector confirmed that laundry services were not provided at this designated centre but were provided on another part of the Claremont campus, but in a separate building and satisfactory arrangements were operating. A new labelling system had been implemented and small discrete labels were sewn into each item of residents' clothing. Laundry was returned to residents by a member of care staff when returned from laundry which took place away from the designated centre.

Residents had access to a lockable space in their bedside locker if they wished to store their personal belongings. There was a policy in place of residents' property in line with the regulations and a list of residents' property was maintained by staff. However, improvements were required relating to records of personal property as outlined in Outcome 5 of this report, as some records were found to be unsigned by staff when admitting to the service, or updating an existing record.

Judgment:

Compliant

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

On the day of inspection the inspector found that the staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents. Overall, the residents, relatives and staff agreed that there were adequate levels of staff on duty and residents needs were met in a timely manner. However, improvements relating to staffing review following untoward incidents and measures to ensure adequate supervision out of hours were required.

The inspector found that there was a very committed and caring staff team. The person in charge facilitated training and continuous professional development for staff. Staff told Inspectors that they felt well supported by the person in charge, her deputy and the management team. Two clinical nurse managers were individually responsible for supervising care in the service. In practice the clinical nurse manager, staff nurses and health care assistants provided direct care and each unit had a daily handover and allocation sheet for each shift, with relevant information about each resident and their changing needs.

The inspector found that the nature of resident dependency had not increased since the time of the last inspection in that residents were both long term and up to four short-term respite admissions. However, improvements were required relating to provision of staff in the evenings and at night based on review of accidents and incident reports and notification to the Authority about one serious incident out of hours.

The inspector found that there were procedures in place for supervision of residents in the communal areas, and additional staffing could be sourced internally for unanticipated leave with a clear system in place that staff were familiar with. The inspector noted that 16 staff were involved with direct care of residents, and supported by catering, activity, household, laundry, portering, administrative and medical staff. However, as outlined in Outcome 1 the statement of purpose did not have accurate details of the staffing complement in place. The inspector reviewed staffing rosters and found that staffing was adequate during the day shift, but reduced to two staff members from 8.15pm every day, which was one staff nurse and one health care assistant to meet the needs of up to 25 residents.

Staffing and recruitment were reviewed with a sample of staff files examined on this inspection. The inspector noted that all relevant documents were present, and vetting procedures were up to date. Administrative supports were in place to assist the provider and person in charge with this requirement.

Staff told the inspector they had received a broad range of training which included falls prevention, wound management, end of life care, infection control, non-violent crisis intervention, dysphagia, and the use of the a revised falls risk assessment tool.

4.3 of the 8.8 whole time equivalent health care assistants employed had completed FETAC Education and Training Awards Council (FETAC) level five or above. Training requirements were regularly reviewed, and the training files to ensure all relevant training was provided in order to meet the needs of the residents. Training was provided for staff in areas such as medication management, fire safety and moving and handling.

The inspector reviewed all files and found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).

Staff told the inspector there were open informal and formal communication within the centre. The inspector found that there were formal arrangements to discuss issues and residents needs as they arose, at nurses meetings and staff meetings held regularly.

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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Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Clarehaven Home
Centre ID:	OSV-0000511
Date of inspection:	10/02/2015
Date of response:	25/03/2015

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 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

Schedule 1 information had not been included such as follows-

- conditions of registration currently in place
- arrangements in place for laundry for residents in receipt of Nursing Homes Support Scheme
- accurate staffing complement to reflect current rosters
- recent changes in number of beds for long term care and short term respite provision.

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

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The statement of purpose has been amended and completed to reflect regulatory requirements.

Proposed Timescale: 25/03/2015

Outcome 02: Governance and Management**Theme:**

Governance, Leadership and Management

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

The annual review of quality and safety has not been completed in line with legislative requirements.

Action Required:

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

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

An annual review of quality and safety had been partially completed at time of inspection. This is now completed.

Proposed Timescale: 25/03/2015

Theme:

Governance, Leadership and Management

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

The governance structure does not currently reflect the up to date arrangements to provide adequate supports to the person in charge.

Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

An additional staff member has now been added to the PPIM and relevant documentation will be forwarded to HIQA .

Proposed Timescale: 25/03/2015

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The resident's guide did not contain specific information for level of service provision for residents laundry under the Nursing Homes Support Scheme.

Action Required:

Under Regulation 20(2)(a) you are required to: Prepare a guide in respect of the designated centre which includes a summary of the services and facilities in the centre.

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

The residents guide has been reviewed and changes made to reflect the level of service provision for resident's laundry.

Proposed Timescale: 25/03/2015

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:

Storage arrangements for archived resident records were unsatisfactory and did not provide for adequate confidentiality.

Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

A room had been identified prior to inspection as a records room. Following consultation with relevant staff this room will be designated from 1st May 2015.

Proposed Timescale: 31/05/2015

Theme:

Governance, Leadership and Management

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

Schedule 3 records of residents' property were not kept up to date or signed and dated.

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 were maintained at the centre but on the date of the inspection were not up to date, dated and signed. This has now been addressed.

Proposed Timescale: 25/03/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

An allegation of abuse was partially investigated by the person in charge, and not included in a final report on the matter.

Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

A robust investigation of the allegation has been completed and a final report has now been completed.

Proposed Timescale: 25/03/2015

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:

The analysis of falls and incidents which took place did not include the times, frequency and staffing arrangements at the time of the incidents.

Action Required:

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

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

An audit of falls was been maintained at the centre. This will now be reviewed to take into account issues highlighted by the inspector.

Proposed Timescale: 30/04/2015

Theme:

Safe care and support

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

Recorded incidents of challenging behaviour were not fully reviewed to mitigate further risks to residents and staff.

Action Required:

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

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

All incidents of challenging behaviour will be reviewed by the PIC to ensure that all measures are taken to minimise any risks to other residents or staff.

Proposed Timescale: 25/03/2015

Theme:

Safe care and support

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

Roof tiles were observed to be a hazard on footpath of two fire external fire escapes.

Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

These tiles have been removed

Proposed Timescale: 25/03/2015

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:

Food supplements which were opened were not stored in the fridge in line with manufacturers guidance.

Action Required:

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

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

Food supplements are now stored in the fridge.

Proposed Timescale: 25/03/2015

Theme:

Safe care and support

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

Two medications opened and stored on the trolley did not have date recorded when they were opened for use.

Action Required:

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

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

The staff has been reminded of the importance of ensuring the date is recorded on medications when opened for use. This is in line with local policy.

Proposed Timescale: 25/03/2015

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

Effective care and support

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

Care plans reviews did not take place at a time that evidenced the involvement of the resident and if appropriate the resident's family.

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

All nursing staff are very familiar with residents and their needs and regularly consult with residents/families and their advocates. Staff have been reminded of the importance of timely documentation of these needs.

Proposed Timescale: 25/03/2015

Theme:

Effective care and support

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

Formal reviews documented by nursing staff were signed by a registered nurse but did not fully evidence actual content of review and did not include all details of the changing needs of residents in all cases.

Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

All nursing staff is very familiar with residents and their needs and regularly consults

with resident. Staff has been reminded of the importance of timely documentation of these needs to ensure that they reflect fully any formal reviews.

Proposed Timescale: 25/03/2015

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Premise requires redecoration and repair internally and externally in line with Schedule 6 requirements in the following areas

- roof repairs identified as needing attention at designated centre further to three leaks
- no call bell in smoking room
- front driveway requires repair
- assisted bath needs repair
- handrail in assisted bathroom needs repair
- no hand washing facilities for toilets beside activities room
- storage arrangements for food supplements, chemicals and household items inappropriate.

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:

The registered provider has highlighted these issues with HSE estates who are : assessing the roof to ensure that any areas that need attention are repaired addressing the front driveway repairs and exploring options to put a hand washing facilities for toilets beside activities room.

The PIC is addressing the call bell in smoking room

The assisted bath has been repaired and the handrail in assisted bathroom has been replaced

Storage arrangements for food supplements, chemicals and household items have been addressed.

Proposed Timescale: 31/05/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staffing levels require review to ensure that all the assessed needs of residents and any supervision requirements are met over the 24 hour period.

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 PIC will undertake a review of staffing levels and activity with the CNM's to ensure that all the assessed needs of residents and any supervision requirements are met over the 24 hour period. This will be monitored on an ongoing basis.

Proposed Timescale: 30/04/2015