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:	New Houghton Hospital
Centre ID:	OSV-0000603
Centre address:	Hospital Road, New Ross, Wexford.
Telephone number:	051 420 553
Email address:	beryl.mckee@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Barbara Murphy
Lead inspector:	Ide Batan
Support inspector(s):	Kieran Murphy
Type of inspection	Announced
Number of residents on the date of inspection:	41
Number of vacancies on the date of inspection:	3

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:
03 March 2015 10:30	03 March 2015 17:30
04 March 2015 08:00	04 March 2015 15:30

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

The purpose of this inspection was to inform a decision regarding the renewal of a registration following an application made by the provider. Notifications of incidents and information received by the Authority since the last inspection in February 2013 were followed up on at this inspection.

This inspection was announced and took place over two days. The person authorised on behalf of the provider, person in charge, assistant director of nursing, administrator and staff team were available in the centre to facilitate the inspection process.

As part of the inspection the inspector met with residents, visitors, and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, clinical and operational audits, policies and procedures, contracts of care and staff files.

There were 41 residents in the centre which has a maximum capacity for 44. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition. The inspectors were satisfied that systems and measures were in place to manage and govern this centre. New Houghton was one of a group of three centres under the management of a single provider nominee of the Health Service Executive. The provider nominee, person in charge, director of nursing and administrator were responsible for the overall governance, operational management and administration of services and resources.

The inspector found the premises, fittings and equipment were in good repair overall. However, there were issues of non compliance in relation to the design and layout of areas of the premises as regards the legislative requirement to protect and promote the privacy and dignity of residents. The premises posed some challenges in the provision of care due to the lack of private space and facilities for residents. All residents were accommodated in multi-bedded rooms. There was not a separate visitors room available.

Pre-inspection questionnaires had been sent to the provider in advance of the inspection for completion by residents and relatives. The feedback on the pre-inspection questionnaires from residents and relatives was mostly one of satisfaction with the service and care provided. Systems were in place to manage risk and safeguard residents while promoting their well being, independence and autonomy. Training and facilitation of staff was provided relevant to staff roles and responsibilities, and further training was planned and to be carried out this year.

Areas for improvement identified included:
Premises issues
Consent/restraint
end of life
care planning
complaints
notifications
staff training

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 inspectors viewed the statement of purpose, which had been updated since the previous inspection. It outlined the ethos and aims of New Houghton Hospital and described the services and facilities that are provided. It contained all the matters prescribed in Schedule 1 of the Regulations.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Effective management systems were seen to be in place in the centre during the inspection. The person in charge was suitably qualified and demonstrated a satisfactory knowledge of the Regulations and the Authority's Standards but did not have the necessary experience to meet the regulatory requirements. Inspectors observed that there were sufficient resources in place to ensure the delivery of safe and quality care to the residents with the present skill mix and staffing levels and recent refurbishments

that have taken place. The person in charge was supported by clinical nurse managers on each floor.

The provider nominee who is responsible for other designated centres had only taken over the role of provider nominee in this centre just before the inspection. She told inspectors that she planned to be on site one day per week and is always available by phone.

At the last inspection it was found that the system for monitoring quality required improvement. A newly devised risk management strategy had been developed which outlined the governance arrangements to be put in place to manage risk and quality. The strategy outlined that adverse events and risk management issues were to be discussed at a risk governance group comprising the hospital manager, director of nursing and the regional risk manager.

However, this group had not yet been put in place. A quality and safety committee was to develop and review policies, procedures and guidelines for the centre. However, this committee also had not yet been put in place. The risk management strategy outlined a process for serious adverse events where the regional clinical risk manager was to complete a review of the event with robust investigations. However this process had not been introduced as yet.

The person in charge had developed a system of quality assurance checks of issues including:
•Twice daily check of controlled drugs
•daily review of health and safety, monitoring of fridge temperatures (including medication fridge), cleaning
•weekly review of resuscitation equipment, wound management and bed mattresses
•monthly audit of hygiene, use of sharps, resident ability to undertake activities of daily living
•three monthly audit of medication, resident falls and staff training.

The person in charge outlined that some of these audit tools had been developed but not yet started as for example with the medication audit tool. There had been an audit of falls for 2014 which outlined that there had been a total of 21 resident falls. An analysis of the falls had looked at the location of the falls, time of day when the falls occurred and the outcome for the resident. When inspectors reviewed the reported falls one of the contributory factors identified by staff was the use of night sedation or anxiety-relieving medication. However, the audit of falls did not specifically comment or analyse this contributory factor.

Additionally, the audit process was not sufficiently comprehensive to monitor the quality and safety of care in the centre. This is supported by the findings of this inspection that identified deficits in a number of areas including medication management restraint, consent, complaints and care planning, all of which will be discussed in further detail under the relevant outcomes of this report.

An annual review of the quality and safety of care was provided to the inspector following inspection. The report outlined that in 2014 some areas for improvement were

identified by the audit cycle and in 2015 it is proposed to remedy these subject to procuring funding. This report was also to be presented at the next resident's forum meeting.

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

Findings:
Inspectors read a sample of completed contracts and saw that they did meet the requirements of the Regulations. They included adequate details of the services to be provided and the fees to be charged, and included the cost for the additional services not included in the fee.

Inspectors saw there was relevant information available for residents on notice Boards and in each unit. Services provided for residents were outlined in a Residents' Guide that included a summary of the statement of purpose, terms and conditions within a sample contract of care, complaints procedure and visiting arrangements.

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

Findings:
The person in charge is relatively new to her post and is an experienced nurse and manager and is actively involved in the organisation and management of the service. In addition to previous clinical and managerial experience the person in charge had continued her professional development and is currently undertaking the dementia

champions course. The inspectors interacted with the new person in charge throughout the inspection process and interviewed her towards the end of the inspection.

She was frequently observed meeting with residents, relatives and staff and ensured good supervision to all staff. The person in charge had suitable deputising arrangements in place. The inspectors were satisfied that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and had demonstrated a commitment to improving outcomes for the resident group. Residents and relatives were familiar with and complimentary of the person in charge.

However, the person in charge does not have the required experience of three years experience of nursing older persons within the previous six years to meet regulatory requirements.

Judgment:
Non Compliant - Moderate

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:
Inspectors were satisfied that the records listed in schedules 2, 3 and 4 of the Regulations were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Records including the statement of purpose, Residents' Guide, and a directory of residents, emergency procedures, and clinical documents along with records related to all residents and staff were available for inspection.

The designated centre had all the written operational policies as required by Schedule 5 of the Regulations. There was a visitor's sign in book on each floor. The designated centre was adequately insured against against accidents or injury to residents, staff and visitors.

Judgment:
Compliant

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:
There were suitable arrangements in place for the management of the designated centre in the absence of the person in charge for more than 28 days.

The person in charge worked full time and was supported in her role by the clinical nurse managers. A clinical nurse manager covered for the person in charge in her absence.

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:
Measures to protect residents being harmed or suffering abuse were in place. A policy on, and procedures for the prevention, detection and response to allegations of abuse was in place. All staff had received training in adult protection to safeguard residents so as to protect them from harm and abuse.

Staff knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to. There were two active incidents of alleged abuse ongoing at the time of inspection. Inspectors requested the two files of these investigations. However, only one file was made available to inspectors during the inspection.

There was a restraint policy in place. The management of residents using bedrails and

wandering bracelets required review particularly in relation to obtaining of consent for same. Residents consent to treatment forms were viewed by the inspector and were found to require review. Best practice guidelines would advocate the discussion of the requirement for restraint with the next of kin but not the signing of the consent which can only be done by the resident. There was no evidence of consent for the use of bed rails and prescribed assessment for the use of a particular type of restraint being obtained from residents. There was no evidence of two hourly release charts in place and there was no evidence of consideration of least restrictive alternatives to restraint.

There was a policy on the management of behaviour that is challenging. However, one resident with behaviours that challenge did have a plan of care to guide staff actions and interventions. Staff spoken with were very familiar with resident's behaviours and could describe particular residents daily routines very well to the inspectors. However, staff had not received training in behaviours that challenge to ensure they have up to date knowledge and skills to respond appropriately. The person in charge told inspectors that she was sourcing appropriate training in 2015.

Residents who communicated to and with the inspector said they felt safe and able to report any concerns. Relatives who participated in the inspection process and completed questionnaires also shared this view. The inspector saw that the visitor's book was signed by visitors entering and leaving the building.

The person in charge managed the finances for a number of residents. There was evidence that residents had consented to the centre being their nominated pension agent. In relation to day to day expenses inspectors observed that two staff members were signing for all transactions with the resident.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
There was an organisational risk register which outlined hazards that the centre required more support to manage. Two hazards had been escalated to the regional management of the Health Service Executive (HSE):
1.The lack of appropriate seating for long stay residents had been identified as a high risk to resident safety
2.staff vacancies had also been identified as a high risk.

The risk management strategy contained the identification and management of risks and there were measures in place to control risks including assault, accidental injury and self harm. There was an incident reporting system to identity hazards and from December 2013 to February 2015 there had been:

• 21 resident falls, which is discussed in more detail in Outcome 2 of this report
• one staff fall
• one incident of attempted taking of resident possessions by another resident
• one reported incident of an outbreak of an infectious disease, clostridium difficile.

There was an organisational safety statement which outlined health and safety hazards including:
• violence and aggression
• manual handling
• slips, trips, falls
• management of waste.

Each identified hazard in the safety statement had been assessed in accordance with an outline of whether it was a low risk, medium risk or high risk. There were controls in place to manage the identified hazards. In some cases there was a need for additional controls, as for example not all staff had received training on the management of behaviours that challenge.

The person in charge had commissioned a health and safety report in January 2015 which identified a number of issues. There was little maintenance and cleaning of the fire escape route from the upper level. The person in charge outlined that this issue had been rectified. The report also highlighted a hazard associated with manual handling and the person in charge said that a number of staff were due to be re-trained. The main issue identified in the health and safety report was the maintenance of the external environment where there were a number of trip hazards, a considerable amount of rubbish throughout the grounds and poor condition of the road up to the centre. A general clean up had been undertaken since then but a costed plan in relation to the entrance road was to be submitted to the HSE.

There was an internal emergency plan which identified the emergency management team to include the director of nursing, clinical nurse manager and engineer. The emergency plan included instructions for staff in relation to issues including fire, evacuation, power outage and flooding. There was a personal emergency evacuation plan available for each resident which identified the supports required by each resident, their nearest exit and a detailed plan of evacuation.

There was a valid fire certificate for the centre dated 08 October 2014. Inspectors saw evidence that suitable fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:
• Servicing of fire alarm system and alarm panel January 2015
• servicing of the emergency lighting January 2015
• staff were checking that the fire extinguishers were intact and the fire panel was in order on a daily basis.
However, the person in charge outlined that six newly recruited staff had yet to receive

fire training. This had also been a finding on the last monitoring inspection by the Authority in 2013.

In relation to the management of infection there had been one reported incident of an outbreak of an infectious disease, clostridium difficile, which affected one resident. Inspectors observed that a care plan had been put in place to manage this infection. While a single room was not specifically available to prevent the spread of the infection, the resident had been moved to an area where he did not have contact with other residents. Barrier nursing had commenced and the infection had been confined to this resident who recovered subsequently.

The centre was visibly clean with a cleaning schedule identifying areas to be cleaned and cleaning frequencies. Staff spoken with were knowledgeable about cleaning and control of infection. Staff described how clothes, linen and towels were separated, stored and washed separately. All linen was washed by an external company. Inspectors reviewed the laundry arrangements in place. The design of the laundry facilities allowed for correct flow and appropriate segregation of soiled and clean items.

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:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The practice of checking, dispensing and recording of the drugs administered was in line with current legislation. Inspectors were not satisfied that the processes in place for the transportation of controlled drugs, was safe. Inspectors were told that these drugs were sometimes transported to the centre in a stapled brown paper bag in a taxi which is not in line with best practice guidelines.

Photographic identification for residents was present. The nurses, spoken with by inspectors, demonstrated a clear understanding of the An Bord Altranais agus Cnaimhseachais na hEireann guidelines on medication management.

The pharmacist provided support on medication management for nursing staff in the centre and nursing staff said that the pharmacist was always available by phone but did not provide an onsite service. However, residents were not afforded a choice of pharmacist or GP as required by the regulations.

There was a good GP service to the centre and all residents automatically came under

this 'medical officer's' care on admission. However, this practice was not in line with Regulation 6 (2) (a) of the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013 which requires that residents are offered a choice of GP. This will be addressed under outcome 11: Health and Social Care Needs.

Residents' medications were seen to be reviewed on a regular basis. Inspectors saw that in a sample of medication charts reviewed that each medication had been individually signed by the prescriber. There were appropriate procedures for the handling and disposal of unused and out of date medicines.

There was evidence that one resident had been referred for review by a consultant psychiatrist who had made recommendations in relation to the reduction of medication. However, when inspectors checked the medication administration record the medication had not been reduced. Nursing staff also re-checked every medication administration record for this resident since this medication reduction had been made and the instructions of the consultant psychiatrist had not been followed.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, the person in charge did not ensure a written report was provided to the Chief Inspector at the end of each quarter in relation to any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used as required by legislation.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective care and support

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

Findings:
The inspectors were satisfied that residents healthcare needs were met to a good standard. Residents had access to GP services and a full range of other services was available on referral including speech and language therapy (SALT) and dietetic services. However, inspectors observed that residents were not afforded a choice of GP as all residents automatically came under a 'medical officer's' care on admission which is not in accordance with the Regulations.

Systems for monitoring the exchange and receipt of relevant information when residents were transferred to or returned from another healthcare setting were in place. Medical records reviewed indicated that residents had access to equitable and timely medical reviews and treatment. Residents had access to other medical practitioners including psychiatric, oncology, surgical and ENT (Ear Nose and Throat) consultants.

Inspectors saw that residents did not have access to occupational therapy (OT) services. Inspectors observed a number of residents in the upstairs dayroom sitting in therapeutic chairs not recommended for them. Documentation seen by inspectors demonstrated that multiple requests for review of residents' chairs had been sent to the community occupational therapy in the last 12 months. The consultant physician who saw residents each month on site had written to the head of occupational therapy in the region regarding this lack of review. He outlined that people who may need special seating are not being assessed and this could increase the risk of getting complications especially in long term frail people.

Chiropody, dental and optical services were also provided. A physiotherapist was available as required. The inspector reviewed residents' records and found that residents had been referred to these services and results of appointments were written up in the residents' notes.

The arrangements to meet residents' assessed needs were set out in individual care plans. Recognised assessment tools were used to determine levels of dependency and care needs, and to assess levels of risk for deterioration, for example vulnerability to falls, nutritional care, and the risk of developing pressure ulcers and moving and handling assessments. There was a record of the resident's health condition and treatment given completed daily.

The inspector read the care plans of residents who had fallen and saw that risk assessments were undertaken and a care plan was devised. Preventative measures undertaken included the use of chair alarms and hip protectors. Questionnaires received by the Authority also indicated that there was good supervision of residents.

There was evidence that some residents were in an unsuitable care environment here and would be more suited to residential accommodation with daily activity facilitated by

the relevant professionals. A prevention and management of challenging behaviour care plan indicated that, since February of last year, 14 episodes of verbal abuse and eight episodes of physical abuse related to a resident. As discussed in more detail in relation to complaints in Outcome 13, four formal complaints had been made to the person in charge in relation to these physical assaults.

Another resident said to inspectors that he had been hit in the face while sleeping and this incident was recorded in the complaints log. There was evidence of input into the prevention and management of challenging behaviour care plan by other healthcare professionals including a liaison nurse in intellectual disability, a consultant physician, consultant psychiatrist, occupational therapist and clinical psychologist. It had been recommended that a more suitable residential placement be found but the person in charge stated that none was available.

There were opportunities for residents to pursue healthy lifestyle choices and recreational activities. There was a healthy living centre on campus and some of the residents attended this centre during the day. There was a varied diet available which will be further discussed under Outcome 15. There was ongoing monitoring of each resident's health status and staff regularly checked residents' weight, blood pressure, diagnostic tests and blood tests. There was an activity programme in place and residents informed inspectors that they were aware of the activities available.

Overall care plans contained the required information to guide the care for residents. In the sample of care plans reviewed there was evidence that care plans were updated at required intervals or in a timely manner in response to a change in a resident's health condition. However, there was no evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated. This has been a finding on previous inspections.

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

Findings:
The physical environment in the centre does not meet the requirements of the

Regulations. The centre was divided into two floors which had a lift from ground to first floor.

Residents' accommodation on the ground floor comprises of five four bedded rooms and one two bedded room all with wash hand facilities for male residents only. There was one bathroom with an assisted bath and an assisted shower with toilet facilities. There was four other toilet facilities, two sluice rooms and two linen/store rooms.

There was a day/dining room with access to a secure sensory garden and one other day/activities room on this floor. There were administration offices, main kitchen, staff facilities, store room, shop and pharmacy room on this floor also.

Residents accommodation on the first floor comprises of five four bedded rooms, one two bedded and one single end of life care room for female residents only. There were two day room/dining rooms, activities room. There was one bathroom with an assisted bath, one assisted shower room with wash hand and toilet facilities. There were four single toilets, two sluice rooms and two linen/store rooms. There was also a pantry, meeting room, staff male and female changing facilities with showers and a pharmacy room.

The centre was clean, comfortable, welcoming and well maintained both internally and externally. There were handrails and safe floor covering throughout the centre. Some appropriate assistive equipment was provided to meet residents' needs such as hoists, specialised beds and mattresses. Inspectors viewed the servicing and maintenance records for equipment such as hoists and found they were up to date.

However the inspectors found that the premises posed some difficulties in the provision of care due to the lack of private space and facilities for residents. The majority of residents were accommodated in four-bedded rooms which afforded little privacy or room for personal storage.

These rooms were generally not personalised. In many cases, lockers and wardrobes were very small and could not accommodate sufficient clothing to allow residents to exercise choice. There was not lockable storage for all residents.

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

Findings:
The process for the management of complaints required improvement. There was a complaints policy which identified the person in charge as the complaints officer. The person in charge outlined that most complaints were managed at a local level by the ward managers. If these complaints could not be resolved they were escalated up to the person in charge.

Inspectors reviewed the complaints log for one ward and found that there had been 13 recorded complaints since January 2014. A number of complaints related to the quality of food being served but the majority related to residents and their families being upset by other residents. In a number of cases the outcome of the complaint was not recorded as being resolved and there was not any recording of whether the complainant was satisfied or not. The inspectors reviewed the complaints log for issues that had been dealt with by the person in charge. There were four complaints and each related to a resident threatening other residents with assault or physically assaulting them. In all cases it was unclear what the outcome of the complaint was. There was not any recording of whether the complainant was satisfied or not.

The inspectors also reviewed the comments received in the comments/suggestion box. There had only been four received for 2014 and each related to a television not working in a particular room. The person in charge outlined that this issue had been resolved but there was not any recording of this on the comments/suggestions log.

Judgment:
Non Compliant - Moderate

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

Findings:
At the time of inspection the inspectors were informed that there were no residents receiving end-of-life care. A thematic inspection had taken place in 2014 and all actions identified had not been addressed. The inspector reviewed the centre's policy on end-of-life care and noted that the policy was still in draft. However, it provided good guidance on the management of the period prior to death and the care of the body. It outlined procedures for end of life care and provided guidance for staff on care planning for end of life and how to provide support to relatives.

Care plans were found to reference the religious needs, social and spiritual needs of the

resident. While care needs were identified on admission and documented accordingly there was no evidence of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell.

Inspectors saw that the religious and spiritual needs of residents were respected and supported. Mass takes place on a weekly basis and the nurse manager told the inspector that any other religious denominations are catered for. A remembrance event for deceased residents takes place on an annual basis. There was also an oratory available for residents and relatives use.

A nurse manager told the inspector that residents had good access to the specialist palliative care services. This was a nurse led service which provided onsite visits to residents and also advice via telephone. There was good access to medical services as evidenced by the medical and nursing records. Documentation such as care plans and medication charts reviewed by the inspector indicated that symptom control was effective for residents to ensure adequate pain relief and comfort.

There was a designated end of life room. Inspectors noted that the privacy of residents was respected as much as possible. As described under Outcome 12 the bedrooms consisted of hospital ward type accommodation.The centre was registered to accommodate 44 residents. There was one single room throughout the centre in total. The multi occupancy bedrooms in each of the wards were not suitable to meet residents' needs due to their design and layout in relation to maintaining privacy and dignity. These multi-occupancy rooms accommodated up to four residents in ward bay type setting. Therefore the option of a single room in the event of more than one resident requiring end of life care could not always be guaranteed for residents.

There was a policy on consent however; inspectors were unclear of the process used to obtain a valid consent in accordance with legislation and current best practice guidelines.

There was evidence in medical records that end-of life care and decisions regarding resuscitation were discussed by the consultant geriatrician in a timely manner with residents and families. The decisions reached were recorded in the medical records. However, there was no evidence of discussion or input from residents or relatives on the record or on a separate consent form to confirm this decision. Inspectors did not observe that these decisions were reviewed or updated. This has been a finding on previous inspections.

Judgment:
Non Compliant - Moderate

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

Theme:

Person-centred care and support

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

Findings:
Residents were provided with food and drink in sufficient quantities to meet their needs. Inspectors reviewed the nutrition policy in place and found it covered the importance of nutrition and adequate hydration. Weights were recorded on a monthly basis or more frequently if required. A number of examples were seen of resident's intake being monitored, and action taken if it was seen to be low.

There were good working relationships with specialist services such as the dietician and speech and language therapist. The inspector observed referrals for consultation to these services and from the records reviewed there was a timely response with assessments undertaken. Access to diagnostic services was through the local hospital or outpatient department. Residents also had access to dental services as observed by the inspector. A sample of medication administration charts were reviewed by the inspector. These indicated that nutritional supplements were prescribed by the GP and administered by nursing staff accordingly.

Individual charts were in use for residents with specific dietary or cognitive needs and staff used communication strategies effectively; the inspectors noted one instance where a resident was encouraged to sign their chart after dining in order to support their comprehension of the routine. Prepared meal trays were also seen to be individualised and reflected the requirements and preferences of residents.

Drinks were available during the meal and were seen to be offered regularly. Meals were prepared in the main kitchen in another centre and transported via hot trolleys in a van from the main kitchen to the kitchenette on the unit. Portion sizes were also appropriate. Meals which were required to be pureed were presented in an appealing manner with identifiable ingredients and a choice of main courses also on offer. The lunch menu was rotated on a three weekly basis and a menu audit had been completed by the dietician in October 2014. There was evidence available on inspection that the dietician was satisfied with the nutritional content of the food also.

Light snacks were available throughout the day and tea trolleys were seen in regular circulation. Afternoon tea was available from 3.30pm with supper served at 5pm. Water was readily available and seen to be regularly on offer by staff.

The inspectors spoke with residents who said that they were satisfied with the food quality and choice. Residents spoken with were complimentary about their experience of the centre and several resident questionnaires completed provided positive returns on satisfaction levels.

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 saw evidence that residents were consulted about how the centre was planned and run. There was a residents' committee on each floor which was chaired by the nurse managers. Residents who spoke with inspectors outlined that that they would feel comfortable to raise any issues or concerns they had at this meeting or with the staff at any time. There was also a suggestions/comments box at reception if any resident, relative or staff member wanted to make any suggestions or comments.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. Residents told inspectors that they were happy because all the staff were very kind.

The community employment programme had provided community employment placement workers and they provided activities Monday to Friday such as

•A range of activities for residents e.g. cards, draughts, bingo, knitting, poetry, flower arranging, crochet, singsongs/reminiscence, birthday parties, videos, Sonas, drama, and baking as observed by inspectors.
•an escort to mass for residents who wish to attend
•an escort to the library, swimming pool and local hotels
•accompany residents on outings during the summer months
•assist with entertainment i.e. visiting musicians, story tellers, getting residents ready and providing refreshments as required.
assist with the production of Life Story books for residents and families who wish to participate
•assist and encourage group activities.

Hand massage was available on each ward aimed specifically aimed at the continuing care of the residents with dementia. Some residents also attended the day centre which was located on site. A chaplaincy service was available to address residents' pastoral needs and offer spiritual guidance and support as outlined in the statement of purpose. Clergy of all denominations are available on an on call basis. The local priest and Church of Ireland Minister visit regularly. Mass was held once per week in the centre. The hospital oratory was located on the ground floor was available for patients to use for

times of reflection and prayer.

Newspapers were available on request and the main news topics were discussed each day. There was an open visiting policy in the centre and residents confirmed that relatives were made to feel welcome in the centre. Inspectors saw many visitors coming and going during inspection. Inspectors saw that residents had access to daily entertainment and leisure facilities such TV, radio, newspapers and magazines.

There were notice boards available providing information to residents and visitors. Staff informed inspectors that every effort was made to provide each resident with the freedom to exercise their choice in relation to their daily activities. Residents were facilitated to exercise their political and religious rights.

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

Findings:
Residents could have their laundry attended to within the centre. Residents expressed satisfaction with the laundry service provided. There were procedures in place for the safe segregation of clothing to comply with infection control guidelines.

Inspectors viewed a number of residents' bedrooms. The majority of the residents share multi-bedded rooms where there was insufficient space for personal possessions and lockable storage was not available to all residents. There was a policy in place in relation to residents' personal property and a list of residents' property was not maintained for all residents.

Judgment:
Non Compliant - Moderate

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

recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Resident dependency was assessed using a recognised dependency scale and the staffing rotas were adjusted accordingly. Inspectors found that there were procedures in place for supervision of residents in communal areas.

The inspectors examined the staff duty rota for a two week period on the two wards. This described the staff complement on duty over each 24-hour period. The inspector noted that the planned staff rota matched the staffing levels on duty. The inspectors were satisfied that the number and skill mix deployed on both wards was adequate to meet the needs of residents.

There was a clear organisational structure and reporting relationships in place. There were designated CNM posts of responsibility on each ward for the supervision of care and services to residents and the supervision and direction of staff. The inspector saw records of regular meetings between these post holders and senior nursing management at which operational and staffing issues were discussed. The inspector saw that staff had available to them copies of the regulations and standards.

The inspectors observed that staff interacted well with residents and residents appeared very comfortable with staff. The inspectors carried out interviews with staff members and found that all were knowledgeable of residents' individual needs, the centre's policies, fire procedures and the guidelines for reporting suspicions of elder abuse. Staff were aware of all policies and procedures about the general welfare and protection of residents.

A staff training matrix was in place and the inspectors saw, based on the records reviewed, that staff had completed recent education and training such as health and safety, elder abuse, nutrition and the older person, person-centred care and dementia mapping, basic life support and end of life care. However, as outlined under Outcome 8 not all mandatory training such as fire training and manual handling was up to date. Training records did not demonstrate that staff had attended recent training on the use of physical restraint and behaviours that challenge as previously outlined in the report as areas requiring improvement to ensure staff provided care in accordance with contemporary evidenced-based practice.

Some staff members told inspectors that they would like to have more training days. Inspectors observed that there was no formal support and supervision available for staff which would identify training needs of individual staff members.

There was a national HSE policy for the recruitment, selection and Garda Síochána vetting of staff. The current registration details were maintained for all nursing staff. An inspector viewed a sample of four personnel files. The files contained all the documentation required under Schedule 2 of the Regulations.

There were no volunteers working in the centre at the time of inspection.

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

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	New Houghton Hospital
Centre ID:	OSV-0000603
Date of inspection:	03/03/2015
Date of response:	01/05/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management strategy had not been fully implemented. Audit tools had been developed but some had not yet started. Some of the audits were not sufficiently comprehensive to monitor the quality and safety of care in the centre.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
As per the newly devised risk management strategy the following is to occur:

Development and commencement of a Quality and Safety Committee which will continuously govern, manage and review all measurable quality key performance indicators. Terms of reference and commencement of committee meetings will commence from 1 May 2015

Proposed Timescale: 01/05/2015

Outcome 04: Suitable Person in Charge

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge does not have the required experience of three years experience of nursing older persons within the previous six years to meet regulatory requirements.

Action Required:
Under Regulation 14(3) you are required to: Ensure the person in charge is a registered nurse with not less than 3 years' experience of nursing older persons within the previous 6 years, where residents are assessed as requiring full time nursing care.

Please state the actions you have taken or are planning to take:
The present PIC has worked in University Hospital, Waterford formerly Waterford Regional Hospital since 2004 as an Assistant Director of Nursing . This experience has ranged with experience throughout the hospital covering all services within the hospital where there would be over 40,342 admissions per year. Over 37% of those admissions would be for over 65 which equates to 14,926 admissions in 2013. As part of the role of ADON Ms McKee did daily ward rounds and would have observed and monitored the care and treatment of all patients including as mentioned the 14,926 admissions over 65 admitted to the hospital. In addition in the area of gerontology Ms McKee has extensive knowledge of diseases such as Parkinson's Disease, Congestive Heart Failure, Stroke and Diabetes which all directly relate to care of the elderly all gained from her ADON experiences. She plans to complete further training in 2015 to enhance her academic career which to date includes as follows: Registered General Nurse, Registered Midwife, Certificate in Intensive Care, Honours Bachelor of Arts in Nursing and a Masters Degree in Leadership and Management Development for Health Care Managers and Doctors

Proposed Timescale: 27/04/2015

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:** Staff had not received training in behaviours that challenge to ensure they have up to date knowledge and skills to respond appropriately. **Action Required:** Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. **Please state the actions you have taken or are planning to take:** Managing challenging behaviour training to commence in June 2015.
Proposed Timescale: 01/07/2015
Theme: Safe care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** One resident with behaviours that challenge did not have a plan of care to guide staff actions and interventions. A behavioural log was not completed on incidents of behaviours that challenge therefore the information was not used to identify triggers and outline preventative and reactive strategies **Action Required:** Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive. **Please state the actions you have taken or are planning to take:** Behaviour Log to be maintained by all staff. Clinical Incidents to be reported. A multidisciplinary team meeting to be organised to include disabilities manager to discuss the future needs of this resident.
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:** Best practice guidelines would advocate the discussion of the requirement for restraint

with the next of kin but not the signing of the consent which can only be done by the resident. There was no evidence of consent for the use of bed rails and prescribed assessment for the use of a particular type of restraint being obtained from residents. There was no evidence of two hourly release charts in place and there was no evidence of consideration of least restrictive alternatives to restraint.

Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
Policy to be implemented to ensure consent and consultation with all residents and next-of -kins. All clients to be reassessed in accordance with policy on restraint.

Proposed Timescale: 01/05/2015

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 person in charge outlined that six newly recruited staff had yet to receive fire training

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:
Fire training for all staff.

Proposed Timescale: 30/04/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors did not see any evidence that residents were not afforded a choice of pharmacist.

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

Please state the actions you have taken or are planning to take:
A satisfaction survey to be carried out amongst the residents to ascertain if all current residents are satisfied with the current pharmacy arrangements. We do explain the arrangements to proposed residents and their representatives and we invite them at this stage to inform us of if they wish to propose their current pharmacist to follow their care pathway if they choose New Houghton.

Proposed Timescale: 05/05/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence that one resident had been referred for review by a consultant psychiatrist who had made recommendations in relation to the reduction of medication. However, when inspectors checked the medication administration record the medication had not been reduced. Nursing staff also re-checked every medication administration record for this resident since this medication reduction had been made and the instructions of the consultant psychiatrist had not been followed.

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:
Following inspection this was reported and action was immediately taken and a safe system of communication has been introduced to ensure this type of incident does not occur again

Proposed Timescale: 05/05/2015

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge did not ensure a written report was provided to the Chief Inspector at the end of each quarter in relation to any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used as required by legislation.

Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
Notifications will be submitted via the portal system as per regulations.

Proposed Timescale: 27/04/2015

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:
There was no evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated.

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:
Three monthly reviews with resident or next of kin.

Proposed Timescale: 30/04/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that some residents were in an unsuitable care environment here and would be more suited to residential accommodation with daily activity facilitated by qualified social care workers. It had been recommended by the relevant multidisciplinary team that a more suitable residential placement be found but the person in charge stated that none were available.

Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Assessment of needs will be carried out prior to any client being admitted to the unit to

ensure that all appropriate quality of life issues are managed.

Proposed Timescale: 27/04/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that residents were not afforded a choice of GP as all residents automatically came under a 'medical officer's' care on admission which is not in accordance with the Regulations.

Action Required:
Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

Please state the actions you have taken or are planning to take:
GP choice will be offered to all new residents on admission to ensure choice.

Proposed Timescale: 27/04/2015

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors saw that residents did not have access to occupational therapy (OT) services.

Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
An Occupational Therapy service is to be sourced through the Primary care team for the needs of the clients

Proposed Timescale: 30/04/2015

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:

The inspectors found that the premises posed some difficulties in the provision of care due to the lack of private space and facilities for residents. The majority of residents were accommodated in four-bedded rooms which afforded little privacy or room for personal storage.

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 4 bedded rooms are spacious with each room being 44 metre squared and there fixed screens between the resident's beds which can be pulled around to fully enclose the bed for privacy.
To ensure more storage is available plan to adapt present wardrobes.

Proposed Timescale: 30/05/2015

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:
There were four complaints and each related to a resident threatening other residents with assault or physically assaulting them. In all cases it was unclear what the outcome of the complaint was. There was not any recording of whether the complainant was satisfied or not.

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

Please state the actions you have taken or are planning to take:
As per the complaints policy all complaints will be dealt with as per the local Complaints policy and Nominated person will detail the investigation and degree of satisfaction of the resident

Proposed Timescale: 05/03/2015

Outcome 14: End of Life Care

Theme:
Person-centred care and support

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

While care needs were identified on admission and documented accordingly there was no evidence of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell.

Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
End of Life Local Policy (Gold standards) to be rolled out which includes advance planning for end of life care wishes to be completed in a timely manner with all residents and their representatives.

Proposed Timescale: 06/06/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The majority of the residents share multi-bedded rooms where there was insufficient space for personal possessions and lockable storage was not available to all residents.

Action Required:
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
Locks to be fitted to storage.
A plan in place to adapt current storage to meet the needs of the clients.

Proposed Timescale: 30/05/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all mandatory training such as fire training and manual handling was up to date. Training records did not demonstrate that staff had attended recent training on the use of physical restraint and behaviours that challenge as previously outlined in the report as areas requiring improvement to ensure staff provided care in accordance with contemporary evidenced-based practice.

Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
A plan in place to ensure all staff have mandatory training.

Proposed Timescale: 27/04/2015

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some staff members told inspectors that they would like to have more training days. Inspectors observed that there was no formal support and supervision available for staff which would identify training needs of individual staff members.

Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
Needs analysis of training needs will take place to ensure all staff needs are met. A performance appraisal system will be put in place and time frame will be 30 June 2015.

Proposed Timescale: 01/07/2015