

**Health Information and Quality Authority
Regulation Directorate**

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



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| Centre name: | Aras Ui Dhomhnaill Nursing Home |
| Centre ID: | OSV-0000313 |
| Centre address: | Loughnakey, Milford, Donegal. |
| Telephone number: | 074 91 63288 |
| Email address: | info@sheephavenhealthcare.com |
| Type of centre: | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| Registered provider: | Sheephaven Investments Limited |
| Provider Nominee: | Catherine Anne McGilloway |
| Lead inspector: | PJ Wynne |
| Support inspector(s): | None |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 38 |
| Number of vacancies on the date of inspection: | 10 |

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 06 July 2015 10:15 To: 06 July 2015 19:45

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

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| 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 07: Safeguarding and Safety |
| Outcome 08: Health and Safety and Risk Management |
| Outcome 09: Medication Management |
| Outcome 11: Health and Social Care Needs |
| Outcome 13: Complaints procedures |
| Outcome 15: Food and Nutrition |
| Outcome 18: Suitable Staffing |

Summary of findings from this inspection

The inspector met with the provider, person in charge and staff members. The person in charge was fully involved in the management of the centre and was found to be easily accessible to residents, relatives and staff.

The inspector found that residents were receiving responsive healthcare that met their assessed needs. The staff supported residents to maintain their independence where possible. The physical environment meets the needs of residents and they enjoy access to a safe enclosed garden. A range of activities were provided that people could choose to take part in.

The nurse management team and all staff interacted with residents in a respectful, warm and friendly manner. Staff demonstrated a thorough knowledge of residents' needs, likes, dislikes and preferences.

This report set out the findings of an unannounced monitoring inspection. This inspection took place over one day. The inspector reviewed progress on the action plan from the previous inspection carried out in January 2014. Notifications of

incidents received since the last inspection was also considered and reviewed on this visit.

A total of 12 Outcomes were inspected. The inspector judged two Outcomes as moderately non compliant. These included Information for Residents and Health, Safety and Risk Management. Six Outcomes were judged as compliant with the Regulations and a further four as substantially in compliance with the Regulations.

The areas of moderate non compliance primarily related to;

The contracts of care required review to outline the cost of all items not included in the overall fee.

Aspects of risk management required review to ensure all identified hazards are well controlled.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider and had been updated in August 2014.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The inspector found that the management structure was appropriate to the size, ethos, and purpose and function of the centre. There was an organisational structure in place

to support the person in charge. The provider met with the inspector and discussed the governance and operational overview required by his role.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge and clinical nurse manager. Clinical data was collected and reviewed. This included information on physical restraint management, wound care and medication management practices.

The inspector found that this information was used to improve the service. A restraint free environment was being promoted. An action plan was developed to respond to audit findings to ensure enhanced individual outcomes for residents.

The findings from audits and quality improvement strategies were discussed by the management team with nursing staff. The audit findings were collated into a report with copies made available to the residents or their representative for their information as required by the Regulations. This was an area identified for improvement in the action plan of the previous inspection.

Judgment:

Compliant

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):

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

Findings:

The system to ensure each resident admitted to the service has a contract outlining the terms and conditions of their occupancy require review. The contract was revised since the last inspection. However, it did not specify the cost of items individually not covered by the overall fee for example escorts to hospital appointments, chiropody and hairdressing.

In the sample of contracts reviewed the signature to both parties was not in place. In some contracts the amount paid by the Fair Deal Scheme was not identified in the contract. The version of the previous contract of care was signed by a resident admitted recently.

Residents admitted for a short term duration had contract of care in place.

Judgment:

Non Compliant - Moderate

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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 has not changed since the last inspection in January 2014. She is a registered nurse and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge.

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 inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice

and provide guidance to staff. Policies requiring review from the previous inspection were updated.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner.

Samples of staff files were reviewed. The files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

The financial controls in place to ensure the safeguarding of residents' finances were examined by the inspector. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions.

A system was in place to manage small amounts of personal money for residents. A record of the handling of money was maintained for each transaction. Two signatures were recorded in each transaction. Receipts were issued. A financial statement was provided to residents or their next of kin detailing all monetary transactions.

The inspector was provided with a copy of the centre's policy on prevention, detection and response to elder abuse. The policy was specific to the centre. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy. The policy was revised since the last inspection.

Residents spoken with stated that they felt safe in the centre. There was a visitors log in place.

The provider and person in charge were qualified trainers in adult protection. Staff to whom the inspector spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. There was an ongoing program of refresher training safeguarding vulnerable adults in place.

Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Síochána vetting forms examined by the inspector.

There is a policy on the management of behaviour that is challenging. Staff spoken with were very familiar with resident's behaviours and could describe particular interventions well to the inspector for individual residents. Seven nursing staff had received training in responding to behaviours that challenge. However, all staff were not trained at the time of this visit.

There was a policy on restraint management (the use of bedrails and lap belts) in place. At the time of this inspection ten residents had two bedrails in use. There was a risk assessment completed prior to the use of the restraint and assessments were regularly revised. Signed consent was obtained by the resident or their representative and the GP. Restraint risk assessments were revised routinely and supported with a plan of care. Crash mats, sensor alarms and ultra low beds were in use to promote a restraint free environment. The rationale for each bed rail was outlined in the risk assessment documentation reviewed.

Judgment:

Substantially Compliant

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The governance arrangements to manage risk situations were specified. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy. However, the risk management policy requires review to ensure it is centre specific. There was no detailed hazard identification with controls to mitigate risk in relation to resident's communal areas, their bedrooms and ensuite bathrooms.

There was an emergency plan and this was found to be appropriate with identification of services and emergency numbers in the event of a range of possible occurrences. This was revised as required by the action plan of the previous inspection. A missing person's policy was in place.

Hand testing indicated the temperature of hot water did not pose a risk of burns/scalds. At the time of this inspection there were a number of unoccupied bedrooms. Records reviewed did not indicate hot water outlets were flushed regularly to minimise the risk of

Legionella. The records reviewed evidenced the last flush on hot water outlets was in January 2015.

The inspector reviewed the fire safety register and training records. Staff to whom the inspector spoke confirmed their attendance at fire training and gave accounts of their understanding of fire procedures in the event of an outbreak of fire. All staff had completed refresher training in fire evacuation since the last inspection and further training was planned for 2015.

Fire safety equipment including the fire alarm, fire extinguishers, emergency lighting and smoke detectors were provided and were serviced quarterly and annually as required. The procedures to follow on hearing the alarm and action to take on discovering a fire were displayed.

Records indicated fire drill practices were completed most recently in March and May 2015. The fire drill records did not record the time taken for staff to respond to the alarm. The drills did not record the scenario/type of simulated practice. Records did not evidence simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced. There was no evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

There were two residents who smoked at the time of this inspection. Risk assessments were completed. A plan of care was in place detailing the level of assistance and supervision required. Cigarettes and lighters were held in safekeeping by staff both during the day and at night.

The training records showed that staff had up-to-date training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. The moving and handling risk assessments detailed the type of hoist required. However, the sling size required by the residents was not specified in all assessment reviewed.

There was not a system in place to ensure each resident with an air mattress had the mattress settings correctly adjusted. The inspector on reviewing a care file checked the resident's air mattress. The air pump was incorrectly set in relation to the resident's weight.

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 was a medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

Each resident's medication was dispensed from individual packages. These were checked on arrival against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident. Drugs which were crushed prior to administration were prescribed and signed. All medication kardex are transcribed. The signatures of two transcribing nurses were in place for each drug on the kardex

The inspector reviewed a sample of drugs charts. The prescription sheets reviewed were legible and distinguished between PRN (as needed), regular and short term medication. Medication was being crushed for some residents. Alternative liquid or soluble forms of the drugs were sought where possible through consultation with the pharmacy. The max dose for all PRN (as required) medication was in place for all drugs in the sample of prescriptions reviewed.

The medication administration sheets viewed were signed by the nurse following administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the balances and found them to be correct.

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 arrangements to meet residents' assessed needs were set out in individual care plans. The inspector found a good standard of care and appropriate medical and allied health care access. There was a good emphasis on personal care and ensuring personal wishes and needs were met.

A range of risk assessments had been completed and were used to develop care plans that were person-centred, individualised and described the current care to be given. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and continence.

The inspector reviewed three resident's care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, a wound problem, potential behaviour that challenges and residents at high risk of falls.

Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector. There was evidence of good communication with relatives when they visited and via the phone. However there was limited documentary evidence that residents or their representative were involved in the development and review of their care plan.

Residents had good access to GP services and there was evidence of medical reviews when required. Access to allied health professionals to include speech and language therapist, dietetic service and occupational therapy were available.

The centre's policy was all residents were for resuscitation unless documented otherwise. A multi disciplinary approach was undertaken to include the resident, their representative and nursing team. However, the clinical judgement of the general practitioner in the consensus decision was not documented in the medical file.

There was not a system developed to ensure residents with a do not resuscitate (DNR) status had the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

Judgment:

Substantially Compliant

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 person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

The complaints procedure was displayed in the entrance foyer for visitors to view. This provided direction where a person could raise an issue with if they had a concern. A comments box was provided for residents or visitors to raise issues.

Aspects of the complaints procedure require review. A designated individual was nominated with overall responsibility to investigate complaints. A nominated person who would monitor that the complaints process was followed and recorded (independent of the person responsible to investigate the complaint) was not identified.

The independent appeals process if the complainant was not satisfied with the outcome of their complaint was not fully meeting the requirements of the regulations. The independent appeals procedures referred residents/complainants to an agency which does not assist to resolve issues of concern on behalf of residents.

No complaints were being investigated at the time of inspection. A complaints log was in place which contained the facility to record all relevant information about complaints.

Judgment:

Substantially 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:

The menu was planned on a rotating weekly basis and all food was cooked fresh. The inspector reviewed the menu and discussed options available to residents. There were nutritious snack options available between meals to ensure sufficient or optimum calorific intake particularly those for those on fortified diets. A trolley served residents mid morning and afternoon offering a choice of tea/coffee and biscuits.

The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and

care staff. Staff interviewed could describe the different textures and the residents who had specific requirements.

However, one resident recently reviewed by the speech and language therapist was not being served food to the consistency advised. While the speech therapist had recommended a minced moist consistency. However, a pureed diet was being served. Copies of the different types of modified diet were available and a copy of the report by the speech and language therapist was available to staff in the kitchen.

Residents had care plans for nutrition in place. There was prompt access to the GP and allied health professionals for residents who were identified as being at risk of poor nutrition. There was ongoing monitoring of residents nutrition and skin integrity. Nutritional screening was carried out using an evidence-based screening tool at a minimum of three-monthly intervals. Each need had a corresponding care plan.

All residents were weighed regularly. Food intake records were well completed where a need was identified. Fluid charts were totalled to ensure a daily fluid goal was achieved.

Judgment:

Substantially 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:

There was an adequate complement of staff with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre.

Information available conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on cardio pulmonary resuscitation, infection control and food hygiene.

However, as identified in Outcome 7, Safeguarding and Safety all staff were not trained in responding to behaviours that challenge.

Judgment:

Compliant

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:

PJ Wynne
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

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|----------------------------|---------------------------------|
| Centre name: | Aras Ui Dhomhnaill Nursing Home |
| Centre ID: | OSV-0000313 |
| Date of inspection: | 06/07/2015 |
| Date of response: | 20/08/2015 |

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 03: Information for residents

Theme:

Governance, Leadership and Management

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

Contracts of care did not specify the cost of items individually not covered by the overall fee for example escorts to hospital appointments, chiropody and hairdressing. In the sample of contracts reviewed the signature to both parties was not in place. In some contracts the amount paid by the Fair Deal Scheme was not identified in the contract.

The version of the previous contract of care was signed by a resident admitted recently.

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

Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

There is an appendix in place in every resident's contract of care which clearly highlights services or items which are not covered by the weekly cost of care fee. As the prices of these services and the items availed of by our residents change regularly we will create an updated price list which will be maintained for inspection by residents and their families at reception.

We will ensure that all contracts of care have the signatures of both parties & that all financial contributions will be identified.

Proposed Timescale: 20/10/2015

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:

All staff were not trained in responding to behaviours that challenge.

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:

Outstanding staff are scheduled to attend the next planned training.

Proposed Timescale: 20/12/2015

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 risk management policy requires review to ensure it is centre specific.

There was no detailed hazard identification with controls to mitigate risk in relation to

resident's communal areas, their bedrooms and en suite bathrooms.

There was not a system in place to ensure each resident with an air mattress had the mattress settings correctly adjusted.

Action Required:

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

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

The policy will be updated detailing hazard identification in the areas stated.

Documentation is being developed to ensure a system is in place to check the settings on all air mattresses daily.

Proposed Timescale: 20/10/2015

Theme:

Safe care and support

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

Records reviewed did not indicate hot water outlets were flushed regularly to minimise the risk of Legionella.

The moving and handling risk assessments detailed the type of hoist required. However, the sling size required by the residents was not specified in all assessment reviewed.

Action Required:

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

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

Hot/cold water taps are being run regularly together with toilet flushing in all unoccupied en-suite bathrooms but we will now ensure signatures apply to each time a toilet is flushed and when the hot/cold water taps are run in unoccupied en-suite bathrooms to provide increased documentary clarity.

The moving and handling assessment is being re-designed to ensure that the size of sling is stipulated.

Proposed Timescale: 20/09/2015

Theme:

Safe care and support

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

The fire drill records did not record the time taken for staff to respond to the alarm. The drills did not record the scenario/type of simulated practice. Records did not evidence simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced. There was no evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required.

Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

We will design a new form to comply with the regulations and incorporating the scenario/type of simulated practice, to reflect a night time situation, to evaluate the learning from the fire drills & to identify improvements that can be made.

Proposed Timescale: 20/10/2015

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 limited documentary evidence that residents or their representative were involved in the development and review of their care plan.

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:

A new form will be drawn up for residents or their representatives to sign following discussion and consultation regarding review of their care plans.

Proposed Timescale: 20/10/2015

Theme:

Effective care and support

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

There was not a system developed to ensure residents with a do not resuscitate (DNR) status had the DNR status regularly reviewed to assess the validity of clinical judgement on an ongoing basis. The clinical judgement of the general practitioner in the consensus decision was not documented in the medical file.

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:

There is a system in place regarding DNR's and this was a once off occurrence however we will develop a new DNR document which will incorporate the need for the GP's signature which will reduce the risk of the GP failing to document the decision in the residents notes.

We will put a system in place to ensure the DNR status is reviewed by the multidisciplinary team, the resident and their family every 3 months

Proposed Timescale: 20/09/2015

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:

A nominated person who would monitor that the complaints process was followed and recorded (independent of the person responsible to investigate the complaint) was not identified.

Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The complaints policy will be enhanced to ensure it is in compliance with the regulations

Proposed Timescale: 20/11/2015

Theme:

Person-centred care and support

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

The independent appeals procedures referred residents/complainants to an agency which does not assist to resolve issues of concern on behalf of residents.

Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

The complaints policy will be enhanced to ensure it is in compliance with the regulations.

Proposed Timescale: 20/11/2015

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

One resident recently reviewed by the speech and language therapist was not being served food to the consistency advised.

Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

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

On the day of the inspection a resident was receiving a pureed diet rather than a diet of "minced moist consistency" which the speech and language therapist had recommended 4 days before the inspection took place (on a Monday morning) & would have been fully implemented within a week of the recommendation being made. We will continue to ensure that all changes to residents dietary needs are implemented in a appropriate and timely manner.

Proposed Timescale: 20/09/2015