**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

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|---|---|
| **Centre name:** | New Ross Community Hospital |
| **Centre ID:** | OSV-0000602 |
| **Centre address:** | Hospital Road,<br>New Ross,<br>Wexford. |
| **Telephone number:** | 051 421 305 |
| **Email address:** | don@newrosscommunityhospital.com |
| **Type of centre:** | Health Act 2004 Section 39 Assistance |
| **Registered provider:** | New Ross Community Hospital Limited |
| **Provider Nominee:** | Mark Walsh |
| **Lead inspector:** | Caroline Connelly |
| **Support inspector(s):** | Kieran Murphy |
| **Type of inspection** | Announced |
| **Number of residents on the date of inspection:** | 36 |
| **Number of vacancies on the date of inspection:** | 0 |

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 25 February 2015 10:15 | 25 February 2015 18:30 |
| 26 February 2015 08:00 | 26 February 2015 17:20 |

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 06: Absence of the Person in charge |
| Outcome 07: Safeguarding and Safety |
| Outcome 08: Health and Safety and Risk Management |
| Outcome 09: Medication Management |
| Outcome 10: Notification of Incidents |
| Outcome 11: Health and Social Care Needs |
| Outcome 12: Safe and Suitable Premises |
| Outcome 13: Complaints procedures |
| Outcome 14: End of Life Care |
| Outcome 15: Food and Nutrition |
| Outcome 16: Residents' Rights, Dignity and Consultation |
| Outcome 17: Residents' clothing and personal property and possessions |
| Outcome 18: Suitable Staffing |

**Summary of findings from this inspection**

This report set out the findings of an announced registration inspection of New Ross Community Hospital by the Health Information and Quality Authority's Regulation Directorate that took place over two days on 25 February 2015 and 26 February 2015.

As part of the inspection the inspectors met with residents, relatives, the provider, person in charge, the assistant director of nursing (ADON), nurses, care staff, the activities coordinator, board members and numerous other staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

New Ross Community Hospital is a voluntary organization that provides care to people in the local community who require non-acute medical, respite, convalescent and palliative care. It is governed by a board of directors who meet monthly and provided oversight on the day to day running of the centre. The centre is currently registered and the registration is due to expire on 13 June 2015 and the provider had applied for renewal of registration. The commitment of the board and staff to the maintenance of the service was evident.

A number of questionnaires from residents and relatives were returned to the inspectors and the inspectors spoke to a large number of the residents during the inspection. The collective feedback from residents and relatives was one of good satisfaction with the service and care provided. However a number of residents and relatives identified issues with the premises and lack of single rooms and private space for visiting as problematic. Others identified that there appeared to be a lack of staff from early evening and said residents often had to wait for supper, medications and to go to bed.

Inspectors were satisfied that residents were provided with sufficient care taking account of their health and social care needs in a supportive community based environment. Residents had good access to general practitioner (GP) services and to a range of allied health professionals.

A wide variety of activities were available for residents via an activities co-coordinator and a group of volunteers. Hairdressing and chiropody services are also provided with optical and dental services arranged as required. Residents had access to safe outdoor space which they used regularly.

Overall the inspectors found that the premises posed numerous challenges in the provision of care to due to the lack of private and communal space and facilities for residents. The majority of residents were accommodated in multi-bedded rooms and there was a lack of general storage for personal property and possessions. There were a number of actions required from the previous inspection. A number had been addressed some were completed and some were partially completed. However there were a number that remained outstanding and the provider continued to be non compliant in these areas such as quality assurance, medication management, the management of restraint, the suitability of the premises, staff training and inadequate storage for residents personal property and possessions. There were a number of Major non compliances that require immediate attention.These issues are discussed throughout the report.

These improvements and others improvements were required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. Improvements required are described under each outcome statement and are set out in detail in the action plan at the end of this report.These included improvements in the following areas:

- the premises
- provision of mandatory training

audit and quality assurance
fire compliance
- staffing levels
- privacy and dignity
- medication management
- protection of resident's finances
- restraint practices
- infection control

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

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose was viewed by the inspectors. It described the service and facilities provided in the centre The ethos of this community care was reflected in day-to-day life, through the manner in which staff interacted, communicated and provided care.

The statement of purpose had been reviewed and updated to include the registration date, expiry date and the conditions attached by the Chief Inspector to the designated centre's registration under Section 50 of the Health Act 2007 and was found to meet the legislative requirements

The inspectors observed that the statement of purpose was in an accessible format to residents and that it was implemented in practice.

**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:**
New Ross Community Hospital was established in 1988. It is a voluntary centre run by a board of directors who oversee the organisational, financial and management of the centre. The board meet regularly and minutes of meetings were available. There are a number of sub committee's established on which various board members sit on and are actively involved in the running of the centre. One of the board members is the nominated Registered Provider. The Director of Nursing is the Person in Charge who is directly responsible for the operational and clinical management of the centre and reports to the registered provider and the board of directors. She is relatively new to the role and has only been in post since 2014. The person in charge is assisted in her role by the assistant director of nursing who acts up in her absence.

The provider is also new to the post of nominated provider but has been a member of the board for numerous years. He is the GP for the majority of residents in the centre and therefore visits the centre on a very regular basis and knew all the residents and their families. He meets with the person in charge on a formal basis to discuss ongoing management issues for the centre.

The person in charge holds meetings with the staff and the last meeting held with the nursing staff was in November 2014 and the last one with the care staff was August 2014. Minutes of all these meetings were viewed by the inspectors which demonstrated communication of relevant issues, however the frequency of these meetings required review to ensure ongoing effective communication particularly in this time of change for the centre.

There was no evidence of the audit of data in relation to accidents, incidents and falls to identify patterns and establish trends and identify areas requiring improvement to ensure quality and safety of systems and care. There were some systems in place to assess the quality of life and safety of care. The inspectors viewed audits completed by the person in charge and staff in areas such as medication management, hand washing, fire safety audit. But the person in charge acknowledged that these were at an early stage and required further development to support appropriate and corrective action being taken in response to clinical audit. This is required to enhance resident safety with clinical and quality of life outcomes for residents.

Inspectors noted a residents' committee met and minutes of these meetings were seen. A resident survey was undertaken in January 2015 and looked at issues such as food, cleanliness, activities, laundry, respect, privacy and staff. The results of this had not been correlated at the time of the inspection and therefore not fed back accordingly and appropriate action taken if required.

Interviews were conducted with the provider nominee and person in charge during the inspection and on previous inspections and they displayed a good knowledge of the standards and regulatory requirements in relation to their relevant roles.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a policy on the provision of information to residents which included the residents' guide. This guide was compliant with the regulations as it contained a summary of services and facilities, the terms and conditions of admission, a summary of the complaints process and the arrangements for visits. The residents guide was seen to be available throughout the centre.

The inspector viewed a sample of the contracts of care. Each resident has an agreed written contract which included details of the services to be provided for that resident and the fees to be charged. The contract also outlined items that were excluded from the fee. The person in charge informed the inspectors that the contract is currently being reviewed and updated in line with forthcoming slight changes to fee structures.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge is relatively new to her post and to the centre where she commenced in July 2014. She is a registered general nurse and holds a bachelor of science degree in nursing and a post graduate diploma in health service management. Training records confirmed she had kept her clinical knowledge current and showed that

she had attended relevant training courses. She works full-time in the post and demonstrated knowledge of the residents and their clinical and social needs.

She was found to be very involved in the day-to-day running of the centre and was found to be easily accessible and well know to residents, relatives and staff who all identified her as the one with responsibility and accountability for the service. The person in charge demonstrated sufficient knowledge to ensure suitable and safe care is provided to residents during the inspection. She demonstrated awareness that there were numerous ongoing non compliances in the centre and had plans in place to address these.

She displayed a good knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

**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 inspectors reviewed a sample of staff files and found that they contained all information required under Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The designated centre had all of the written operational policies as required by Schedule 5 of the Regulations. The directory of residents in the centre contained the information required by Schedule 3 of the Regulations for all residents.

The centre was adequately insured against accident or injury and insurance cover complied with the all the requirements of the Regulations.

Inspectors found that although, required records were present the records reviewed

were not all maintained in a manner so as to ensure completeness, accuracy and ease of retrieval as records tending to be between various offices and the most up to date version of a document was not always to hand and this could lead to errors.

**Judgment:**
Substantially 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 had been no period of 28 days or more when the person in charge was absent from the centre and the provider demonstrated that he was aware of the obligation to inform the Chief Inspector if there is any proposed absence.

The person in charge is supported in her role by an assistant director of nursing (ADON). The ADON acts up in the absence of the person in charge and is supported by the provider and administrator.

The ADON was interviewed by the inspectors and was found to be experienced nurse with managerial experience. The inspectors were satisfied that she demonstrated an awareness of their responsibilities of being in charge of the centre under the legislation.

**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):**

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

**Findings:**
Inspectors saw that there was a policy document on elder abuse which defined the various types of abuse and outlined the process to be adopted to investigate abuse issues should they arise. Inspectors found that there were some measures in place to protect residents from suffering harm or abuse. Staff interviewed by the inspectors demonstrated a good understanding of elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. The ADON had undertaken a train the trainer in protection and elder abuse prevention and provided training to staff. However training records reviewed by the inspectors did not demonstrate that all staff had received this mandatory training and many staff had received training early in 2012 with no further refresher training. Volunteer staff also had not received elder abuse training. The ADON told the inspectors she planned to run training for all staff and would include the volunteers over the next number of months. The inspectors confirmed that this training needed to be prioritised.

Records of residents invoicing for care were maintained in accordance with best practice guidelines. However it was identified that the records maintained of money and valuables handed in by a resident/relative for safekeeping were not sufficiently robust. Money and valuables were stored in the safe, transactions were generally signed and witnessed by resident/relative and staff members, however the inspectors saw that there was items of jewellery handed in stored in an envelope with no corresponding record available. There was also a discrepancy in the amount of money that was in one resident's accounts. These practices did not safeguard resident's finances and were not in accordance with the requirements of Schedule 3.

There was a policy on challenging behaviour and staff were provided with training in the centre on behaviours that challenge in November 2014 which was confirmed by staff and training records. There was evidence that residents who presented with any behaviour that challenged were referred to psychiatry of old age or other professionals for full review and follow up. The inspectors saw evidence of positive behavioural strategies and practices implemented to prevent behaviours that challenged.

There was a policy on restraint and the centre maintained a restraint registrar, however the inspectors found the restraint register did not include residents that were using wandering tags and residents who were administered psychotropic medications to manage behaviours. The person in charge said she was endeavouring to reduce restraint in the centre and said there were fewer residents using wandering tags now. There were no statistics available on this for comparison or review. Assessments were seen for the requirement for bed rails but there were no comprehensive assessments available for residents using wandering tags. The practices around restraint all required review to be in line with national policy as published on the department of health website.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Safe care and support

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

**Findings:**
The management of fire safety required improvement. During a scheduled activation of the fire alarm on 7 January 2015 it was noted that the doors in four bedrooms and a female toilet were not closing fully. During a further scheduled fire alarm activation on 21 January 2015 the same faults were recorded had not been rectified up to the date of this inspection. Inspectors made the person in charge aware of these findings and these faults were corrected while inspectors were on site. But the inspectors expressed concern re lack of action to these identified faults prior to this which posed serious risks to the residents.

There were ineffective systems and processes in place to manage and maintain the fire register. The fire register recommended a quarterly inspection of emergency lighting by a competent person. However the last records available were for September 2014 and were out of date. The fire register outlined that there was to be a daily check of means of escape routes. However there were a number of days when this had not been done. Similarly there was provision for a weekly test of emergency lighting and this was also not been completed as recommended by the fire register. In relation to fire training the person in charge outlined that one member of staff was qualified to train all other staff on fire safety. However, not all night staff had received this fire training.

The person in charge had introduced in January 2015 an audit of health and safety non-compliances. This audit had identified a number of issues including a fire exit door being blocked by a trolley of dirty linen and the fire door to the laundry being wedged open. The person in charge had notified staff of these issues when they occurred. However, the same issues were observed by inspectors while walking through the premises.

There was confirmation, dated 23 November 2014, from a properly and suitably qualified person that all statutory requirements relating to fire safety and building control had been complied with. Inspectors saw evidence that some fire prevention equipment was provided throughout the centre and the equipment was adequately maintained by means of:
• servicing of fire detection and alarm system January 2015
• fire extinguisher servicing and inspection February 2014

Improvements were required in the prevention and control of infection, including the management of healthcare acquired infection. There was an infection control policy. One

resident had been identified on transfer from an acute general hospital as having a methicillin resistant staphylococcus areus (MRSA) infection. It was specifically outlined in the discharge letter from the hospital that the resident was being treated with medication for this MRSA infection. On admission to the centre, this treatment was continued and a nursing care plan had been developed which advised that the MRSA should be reviewed after treatment for status update. However, the person in charge confirmed that the status had not been checked after the treatment had finished.

Inspectors reviewed the laundry arrangements in place. The design of the laundry facilities and the procedure described by staff in relation to the management of laundry items did not allow for correct flow and appropriate segregation of dirty and clean items. This practice compromised the prevention of cross contamination. In addition staff were observed bringing rubbish bags through the laundry to put in the waste containers outside.

Wooden chairs were observed being used in toilet areas. One chair was placed right next to the urinal in the men's toilets. The person in charge outlined that these chairs were there for residents to sit on if they needed to sit down while shaving or washing. However the chairs were of a design and style that they could not and be easily cleaned and disinfected to minimise the risk of transmission of infection. It also wasn't clear if these chairs were part of the cleaning schedule for the bathrooms.

The risk management policy 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 process and since July 2014 there had been:
• 57 resident falls
• 2 episodes of residents choking
• 1 problem with equipment
• 1 incident of a staff member being struck
• 1 minor burn
However the incident form, while including contributory factors relating to each incident, did not include a review to state how to prevent recurrence of the incidents.

The person in charge outlined a process whereby blood samples for testing were left by GPs and patients from the community in the centre to be delivered to an acute hospital. A risk assessment wasn't available around this process.

There was a policy on the management of internal emergencies including fire, evacuation, electrical outage and winter storms. However there wasn't a personal emergency evacuation plan available for each resident. Due to the dependency level of residents and the fact that most residents were in multi-occupancy rooms, inspectors formed the opinion that that individual evacuation plans needed to be available for each resident.

**Judgment:**
Non Compliant - Major

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

**Findings:**
There were centre-specific policies in place to support the practice of medication management. The inspectors observed nurses administering the medications, and this was generally carried out in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidelines 2007. However the inspectors observed a nurse handling the tablets which was not in line the guidelines or with infection control best practice.

The prescription charts were viewed by the inspectors photographic and written identification was present on all charts. There was a General Practitioner's (GP's) signature for each medication prescribed and discontinued. Each resident's medication regime was routinely reviewed on a quarterly basis by the GP. However crushed medications were not individually prescribed by the GP as is required by legislation.

Inspectors observed that nursing staff were transcribing medications. However, transcribed orders were not co-signed and dated by the transcribing nurse as observed by inspectors. This practice increases the risk of error and does not meet An Bord Atranais guidelines on medication management or the centres own policy and procedure guidelines. This was also identified as a non compliance on a previous inspection.

Medications were generally stored and disposed of appropriately in line with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management (2007). The medication fridge stored medication at the appropriate temperature and there were suitable records available in relation to the regular temperature monitoring of the fridge.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Nurses were checking the quantity of medications at the start of each shift. Staff spoken with and the inspection findings supported competency in medicines management practice.

There was no evidence of ongoing medication management audit in the centre to enhance outcomes for residents.

**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):**
No actions were required from the previous inspection.

**Findings:**
A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector. Quarterly notifications had been submitted to the Authority as required and within the appropriate time frame.

**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 centre had sufficient GP cover and an out of hour's service was also provided by the local doctor on call service. Residents were seen by a GP within 24 hours of admission. Records confirmed that residents had timely access to GP services and were reviewed regularly by a GP which included regular medication reviews. As previously outlined in the report the inspectors met one of the GP's, who is also the nominated provider for the centre.

Residents had access to a range of other health and social care services. Records were maintained of referrals and follow-up appointments. The centre had the services of a dietician one day per month. Chiropody services were provided in the centre as required. Physiotherapy, occupational therapy and speech and language therapy were also available through community services on referral by the GP.

Inspectors reviewed a selection of care plans, the centre had recently transferred to an

computerised system for documentation. Residents had assessments completed on admission which included; dependency level, moving and handling, falls risk, pressure sore risk assessment, nutrition, and mental test score examination. These assessments were generally repeated on a three-monthly basis or sooner if the residents' condition had required it. The person in charge and staff demonstrated an in-depth knowledge of the residents and their needs. There was evidence of ongoing monitoring of incidences involving residents including trips, slips and falls. Inspectors noted that residents' weights were also monitored and recorded at a minimum each month and more often if required. There was evidence that the care plans were reviewed generally every three months and reflected any change to resident's care and there was also some evidence in the care plans of residents having been consulted in relation to their care provision. The inspectors noted that care plans viewed were generally comprehensive and personalised to the residents to promote person-centred care.

There were centre-specific policies and procedures in relation to wound care and wound assessments were evident in care plans for residents with ulcers or wounds. There were also wound management plans available that included the monitoring of the healing of pressure ulcers by utilizing photographs and recording the care provided. These photographs/wound care plans assisted staff in obtaining precise information about the size, shape, colour and progress of these wounds and provided ongoing scientific assessment and measurement of the wound and wound bed. Therefore there was ongoing evidence of improvement or deterioration of the wound.

Residents and relatives said they were satisfied with the healthcare services provided. Documentation in place indicating that information about residents was provided and received when they were absent or returned from another care setting, home or hospital.

**Judgment:**
Compliant

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

**Theme:**
Effective care and support

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

**Findings:**

The centre occupies the ground level floor of a two-storey facility built in the 1930s. It is located on Health Service Executive (HSE) grounds. The accommodation is divided into two wings. Male residents are generally allocated rooms in the left wing while female residents are accommodated in the right wing. However, this arrangement depends on the mix of residents admitted to the centre at any one time. There are two wards located at the end of each wing and each contains nine beds. There are also four single bedrooms, two twin-bedded rooms, two three -bedded rooms and one four-bedded room. An assisted bathroom, shower and toilet are located in each wing.

An extension to the back of the main building in 2002 included a very bright dining and sitting room joined by a conservatory. There is decking with seating for residents that can be accessed from the conservatory. Within the original building, there is a prayer room and adjacent to this is a smoking room. Inspectors noted that there was evidence that the premises was well maintained with a good standard of décor and that efforts had been taken where possible in creating an atmosphere of comfort through the use of some suitable fittings and furnishings.

However, the premises consisted mainly of ward-type accommodation and the physical environment was not suitable for the purpose of achieving the aims and objectives as set out in the statement of purpose and was not conducive to meeting the needs of residents. The inspector found that the centre required a number of actions to ensure it met the requirements of legislation. The majority of residents were accommodated in the two nine-bedded rooms and other multi occupancy rooms which afforded little space and did not ensure that residents' privacy and dignity was met on a daily basis. This was mainly due to the limited space provided in the areas surrounding the beds. Residents' privacy and dignity was significantly compromised due to the close proximity of many of the beds. In these bedrooms, inspectors observed that residents were not able to undertake personal activities in private or meet with relatives in private. The option of a single room in the event of a number of residents requiring end of life care could not always be guaranteed. In most cases, lockers and wardrobes were quite small and did not accommodate sufficient clothing to allow residents to exercise choice. There was no lockable storage for residents.
There was no separate visitor's room and there was insufficient communal space or seating for relatives to visit in the day room.

The above issues were identified on the last and previous inspections and were identified as major non compliances. The provider, person in charge and the board acknowledged the shortcomings and outlined the plans for a major renovation of the centre which included an extension. Costed time bound plans are required to be forwarded to the Authority in relation to same.

**Judgment:**
Non Compliant - Major

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

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

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

**Findings:**
There was a written operational policy and procedure for making, handling and investigating complaints from any person about any aspect of the care or service provided. The complaints procedure contained an independent appeals policy. The complaints procedure was on display in the main foyer and at other locations in the centre.

The complaints log viewed by inspectors and although there were some complaints documented these dated back to 2012. When questioned about this the person in charge said there were issues identified to her which she had documented as note to file and had not logged them as complaints. The inspectors saw these notes to file and clearly identified them as complaints. Therefore these issues were not identified as complaints; there was no full investigation into the matters documented, no evidence of action taken and outcomes of these complaints and whether the complainant was satisfied as required by legislation.
Also there was no evidence of learning from complaints to enhance care and practices in the centre.

**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:**
Since the last inspection a comprehensive policy for end of life care was in place covering issues like comprehensive assessment on admission, assistance with advanced care directives and giving residents the option of a single room. However, some of these guidelines were not being implemented in practice. In particular the centre did not have designated single rooms for residents at end of life. The person in charge outlined that if

a single room was available this was offered to the resident and their family.

At the last inspection the person in charge outlined a project of advanced care planning with all residents who could consent to that process. This initiative had been undertaken in conjunction with the drafting of a policy on communicating cardiopulmonary resuscitation (CPR). This process had still not been fully completed.

Since the last inspection guidelines had been approved to give staff direction following the death of resident. The guidelines included verification of death recording, notification of the death to the Coroner, liaison with the undertaker and the return to pharmacy of unused medication. In the healthcare file of a recently deceased resident these guidelines had been followed. Tastefully decorated hold-all bags were available for the return of a resident's property to family.

There was evidence of appropriate and timely review of residents by medical practitioners and allied health professionals including the dietician. Healthcare files reviewed showed timely referral to the palliative care team with appropriate pain management plans put in place.

There was an oratory with ample seating for residents to attend services or for reflective time. There was unrestricted access for families when residents at end of life but as discussed previously there was limited visiting space particularly if the resident was in a multi occupancy room.

A number of staff had attended specific training courses on end of life care. The activities coordinator had completed a course on the spiritual dimensions of end of life care.

**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:**
There was an up to date policy on nutritional status and management.

As on the last inspection, most residents were served breakfast at their bedside between

the hours of 08:00hrs to 09:30hrs. There was a choice on the breakfast trolley of porridge and cereals, toast, tea/coffee and orange juice. The person in charge outlined that a survey had been undertaken where all residents expressed their preference to have their breakfast at their bedside. One resident said to inspectors that she "preferred her own space" to have her breakfast.

A menu plan was available on a three weekly cycle and input was received from the dietician to ensure the nutritional value of residents' meals. Recommendations from the dietician and/or speech and language therapist were communicated to the catering staff. Up to date copies of each resident's dietary requirements were maintained in a communication folder in the main kitchen. Separate communication folders on speech and language care plans, residents requiring assistance and dysphagia were also available in the dining room.

Lunch and tea was served in the dining room with two sittings, the first for residents who required assistance and the second sitting for residents who could eat independently. The tables were set in an attractive manner and staff were observed assisting residents, particularly residents with a cognitive impairment, in a sensitive manner.

There was access to fluids and snacks throughout the day and tea trolleys were seen in circulation.

The most recent Environmental Health Officer report was available and although there were a number of non compliances the person in charge showed the inspectors the action taken to rectify same.

**Judgment:**
Compliant

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

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

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

**Findings:**
Residents who spoke to the inspector said that staff addressed them respectfully and that screening curtains were used in shared rooms when personal care was being

delivered. However, as identified previously the inspector found that residents did not have sufficient space and privacy. The size and layout of the multi occupancy rooms meant that there was very little space between some of the residents' beds. Residents were unable to undertake personal activities in private. The inspectors observed that some residents were trying to rest while another resident was talking beside them.

Residents' privacy and dignity was also not protected in that inspectors observed an extensive array of communal clothing in the laundry room which impinges on the dignity of residents.

Staff to whom inspectors spoke outlined that all residents were orientated into the centre by the nurse on the day of admission and that all staff wore name badges. There were notice boards available in the premise 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.

The person in charge outlined that there were also arrangements in place to ensure that the centre was managed with due regard to the individual resident's religious, racial, cultural and linguistic background. Inspectors noted that staff consulted residents in the participation in the organisation of the centre and there were residents' committee meetings held regularly to ascertain residents' views. The minutes of the committee meetings were viewed by the inspector and although issues identified at the meetings were brought forward to the person in charge the minutes did not reflect action taken and were not made available to residents.
Inspectors noted that a survey had been completed in relation to residents' satisfaction with services provided in the centre but results of same were not available.

The centre has signed up to be part of the national advocacy programme and there were external independent advocates available to residents or relatives should they wish to obtain help to make a complaint or require assistance to express their views.

The centre had adequate daily entertainment and leisure facilities such TV, radio, newspapers and magazines. A dedicated activities co-ordinator was available to the centre and a further part time staff member was also available and dedicated to undertaking activities with the residents. They initiated and supervised a range of activities and outings which the inspectors saw ongoing during the inspection. The inspectors saw residents participating in and enjoying the various activities and residents told the inspectors how important and beneficial they were to them. The activities co-ordinator organised a group of volunteers who assisted with the activity programme.

There was a good level of visitor activity throughout the days of inspection with visitors saying they generally felt welcome to visit. The inspectors met and spoke with a number of visitors who indicated that they had open access to visit their relative. However as previously outlined, there was not private space available for visiting.

**Judgment:**
Non Compliant - Moderate

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

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

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

**Findings:**
There was a policy for the management of residents' accounts and personal property. A sample of residents' records indicated that records of residents' property was created on admission. Residents' clothing is appropriately labelled and sent to be laundered in the centres laundry. There had been a number of complaints seen in the questionnaires in relation to clothing going missing when sent to the laundry and a number of relatives take the clothing home to wash. As discussed in the previous outcome there were a large number of unmarked clothes and underwear seen in the laundry room that did not appear to belong to any particular resident. The person in charge is aware of the shortcomings with the laundry service.

As stated in Outcome 12, due to multi-occupancy rooms there was insufficient space for all residents to store their own clothes and some were stored centrally in the laundry room in named boxes away from residents. In addition, inspectors observed that due to the lack of space, residents displayed minimal personal effects which was also confirmed by staff to whom inspectors spoke.

**Judgment:**
Non Compliant - Major

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

**Findings:**
Inspectors observed appropriate interactions between staff and residents and they observed staff chatting easily with residents. Residents and relatives told the inspectors that staff were very kind and caring. There was a clear organisational structure and reporting relationships in place and staff were aware of this. The inspector saw that staff had available to them copies of the regulations and standards.

There was a policy for the recruitment, selection and Garda Síochána vetting of staff. The current registration details were maintained for nursing staff. The inspectors viewed a sample of staff personnel files. These files were well organised contained all the documentation required under Schedule 2 of the Regulations.

Inspectors viewed the staff training records which also identified staff who were due training. Staff to whom inspectors spoke were familiar with the training programme and confirmed to inspectors training they had attended or training they were due to attend. The person in charge confirmed that staff education and personal development was facilitated and provided records of a staff training schedule which included the following:

- adult abuse training
- infection control/hand hygiene training
- end of life training
- manage behaviours that challenge
- heart saver cardiac pulmonary resuscitation
- fire training and evacuation
- manual and people handling.

As previously identified not all staff had up to date mandatory training and this required addressing as soon as possible.
The ADON said Volunteer staff were also being trained in moving and handling

The inspectors reviewed the staffing levels and found that staffing levels decreased from the afternoon onwards and the centre operated with one nurse and two care staff for the evening and the night from 20.00hrs. The night nurse had to do the night time medication round and therefore this left only two members of staff to give out evening drinks and assist residents to bed and with other personal care needs. The inspectors found that these staffing levels were not adequate to ensure the nurse administered the medications safely without interruption and to ensure residents had a choice in bedtimes. A number of questionnaires received from residents and relatives identified this time as a time they were all concerned about in relation to the staffing levels and said residents often had to wait for their supper and to be assisted to bed.

**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:*

Caroline Connelly
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 report**[1]

| | |
|---|---|
| **Centre name:** | New Ross Community Hospital |
| **Centre ID:** | OSV-0000602 |
| **Date of inspection:** | 25/02/2015 |
| **Date of response:** | 14/04/2015 |

## 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:**
There was no evidence of the audit of data in relation to accidents, incidents and falls to identify patterns and establish trends and identify areas requiring improvement to ensure quality and safety of systems and care. The person in charge acknowledged that audits completed to date were at an early stage and required further development to support appropriate and corrective action being taken in response to clinical audit to enhance resident safety with clinical and quality of life outcomes for residents.

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

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

**Please state the actions you have taken or are planning to take:**
The Person- in- Charge together with a member of the Board of Directors is undertaking an exercise in the trending of accidents, incidents and falls in the centre. A range of new audits based on resident care (documentation, rights) are being developed.

**Proposed Timescale:** 15/05/2015

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that although required records were present, the records reviewed were not all maintained in a manner so as to ensure completeness, accuracy and ease of retrieval as records tending to be between various offices and the most up to date version of a document was not always to hand and this could lead to errors.

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

**Please state the actions you have taken or are planning to take:**
A review of all documentation and records will take place; out of date documentation will be disposed and documentation and records organised for ease of retrieval.

**Proposed Timescale:** 31/05/2015

**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The reasons for the use of restraint were not always clearly assessed or recorded and the use of restraint is not in line with the national policy on 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:**
The Person in Charge will review the restraint policy and documentation on restraints and develop a wandering alarm assessment tool together with nursing staff to ensure practice is in line with national policy.

**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:**
There was not evidence that all staff had received elder abuse training and many staff required refresher training.

**Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
All staff and volunteers will be trained in Elder Abuse by the proposed timescale.

**Proposed Timescale:** 22/04/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The systems in place to manage residents finances and valuables handed in for safekeeping was not sufficiently robust.

**Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**
Following the inspection a process was implemented which ensures residents finances and valuables are audited on a bi-monthly basis and therefore are up-to-date.

**Proposed Timescale:** 14/04/2015

**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 incident report form did not include a review to state how to prevent recurrence of the incident.

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

**Please state the actions you have taken or are planning to take:**
A new template for incident reporting is in development. This will include actions required to prevent the recurrence of a similar incident.

**Proposed Timescale:** 20/04/2015

**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 a process whereby blood samples for testing were left by GPs and patients from the community in the centre to be delivered to an acute hospital. A risk assessment wasn't available around this process.

**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:**
An immediate risk assessment was carried out regarding the storage of samples. All relevant GP surgeries were contacted in writing and requested to arrange one drop of samples each day. This process is scheduled to be reviewed at the end of May 2015.

**Proposed Timescale:** 14/04/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Care plans in relation to methicillin resistant staphylococcus areus (MRSA) infection

were not being followed.

The wooden chairs in toilets were of a design and style that they could not and be easily cleaned and disinfected to minimise the risk of transmission of infection. It also wasn't clear if these chairs were part of the cleaning schedule for the bathrooms.

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

**Please state the actions you have taken or are planning to take:**
The Person in Charge together with nursing staff will ensure resident care plans are followed in line with relevant policies.

All wooden chairs have being disposed of and replaced with washable plastic bathroom chairs. The cleaning of all toilet and bathroom equipment is included in the household cleaning schedules.

**Proposed Timescale:** 14/04/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The design of the laundry facilities and the procedure described by staff in relation to the management of laundry items did not allow for correct flow and appropriate segregation of dirty and clean items. This practice compromised the prevention of cross contamination. In addition staff were observed bringing rubbish bags through the laundry to put in the waste containers outside.

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

**Please state the actions you have taken or are planning to take:**
It is planned to move the laundry to a building located at the back of the hospital. In the interim staff have been instructed to use appropriate routes to access the waste containers kept at the back of the hospital.

**Proposed Timescale:** 30/06/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were not adequate arrangements in place for maintaining all fire equipment as the emergency lighting had not been checked since September 2014.

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

**Please state the actions you have taken or are planning to take:**
The Person in Charge has arranged with a contractor for service of both the fire equipment and emergency lighting. A member of staff is assigned to monitor this arrangement.

**Proposed Timescale:** 14/04/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provider could not guarantee adequate means of escape as fire doors were blocked and fire doors were wedged open.
It was also noted that fire exits were not being checked on a daily basis as required in their own fire register which also recommended the provision for a weekly test of emergency lighting and this was not completed as recommended by the fire register.

**Action Required:**
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
The Person in Charge is reviewing staff records in fire training to ensure all staff are trained; and has emphasised to staff the importance of fire safety awareness and compliance.

To ensure compliance in completing the fire register (to include the daily and weekly fire checks) the Person in Charge is moving the fire register from the nurses' station to the fire panel area.

**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:**

Not all staff had received 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:**
A review of the fire training records is being undertaken and the required training will take place by the proposed timescale. Otherwise all fire training will take place in July of each year; this will ensure all new staff will be trained.

**Proposed Timescale:** 30/04/2015

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A number of medication management practices required review to be in compliance with professional guidelines and legislative requirements.
• nurses were not following professional guidance in relation to transcriptions of prescriptions
• medications to be crushed were not individually prescribed by the general practitioner (GP)
• a nurse was seen to handle tablets

**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:**
Medication management will be audited as part of the quarterly auditing at the centre. All transcribed documents will be signed by two nurses and medications requiring crushing will be individually signed. Nursing staff will complete up to date training on medication management as well as competency assessments throughout the year.

**Proposed Timescale:** 08/05/2015

**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:**
There were a number of areas where the premises did not meet the requirements of schedule 6

- lack of private space.
- lack of storage space for residents' use
- lack of private space for visiting.

lack of storage space for equipment

**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:**
Post refurbishment and building development works no long-term resident will be accommodated in more than a two bedded room. In the interim the smoking room will be transferred to the internal courtyard area and that room converted to a sitting room/visitors' room. The moving of laundry to an external building will allow for additional storage for equipment.

The design team for the building development works meet today, 14th April. Following on from the meeting the Provider will issue cost and time bound plans to HIQA.

Proposed Timescale: June 2015 (major renovation works separate time bound plans to HIQA by 30th April 2015)

**Proposed Timescale:** 30/06/2015

**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 complaints made to the person in charge which were not logged as complaints, there was no full investigation into the matters documented, no evidence of action taken and outcomes of these complaints and whether the complainant was satisfied as required by legislation.

**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:**
The Person in Charge has converted the notes to file to complaints and provided the documents to staff, the investigation recorded and the actions and outcomes will be communicated with staff through the information folder in the staff room.

**Proposed Timescale:** 30/04/2015

**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:**
The centre did not have designated single rooms for residents at end of life.

**Action Required:**
Under Regulation 13(1)(d) you are required to: Where the resident approaching end of life indicates a preference as to his or her location (for example a preference to return home or for a private room), facilitate such preference in so far as is reasonably practicable.

**Please state the actions you have taken or are planning to take:**
A resident's preference approaching end of life is fundamental and is upheld in so far as is reasonably practical. Assessments and care planning for end of life are ongoing and due to be completed within the proposed time scale.

**Proposed Timescale:** 31/05/2015

**Outcome 16: Residents' Rights, Dignity and Consultation**

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The size and layout of the multi occupancy rooms meant that there was very little space between some of the residents' beds. Residents were unable to undertake personal activities in private.

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

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

The building development works, once complete, will address this issue. In the interim the bed space between each bed will be reviewed and altered as required (e.g. change the side of which the wardrobe is at) to allow more personal space for the resident.

**Proposed Timescale:** 30/04/2015

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was not private space available for visiting in the centre.

**Action Required:**
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

**Please state the actions you have taken or are planning to take:**
The building development works, once completed, will address this issue. In the interim the smoking room/visitors room will be converted to a sitting room/visitors' room and the smoking room will be moved to the internal courtyard. The reflection room is also used as a visitors' room and private area for the residents and their family and friends.

**Proposed Timescale:** 30/06/2015

**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:**
Residents do not have adequate space to store their clothing and personal possessions

**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:**
Each resident and/ or his/her family member/representative extensively reviewed their clothes and possessions. The wardrobes and lockers were tidied and clothing too small or big for the resident was taken home. Bulkier items (e.g.winter coats) are being stored, clearly labelled in the linen room.

When the proposed building development works are completed residents will have more

space for clothing and personal possessions.

**Proposed Timescale:** 14/04/2015

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Issues were identified with the laundry service with residents clothing going missing

**Action Required:**
Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

**Please state the actions you have taken or are planning to take:**
The Person in Charge is reviewing alternative labelling for residents' clothing. All family members have been reminded to give new items of clothing to staff for labelling. These new processes will be reviewed in June 2015.

**Proposed Timescale:** 31/05/2015

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspectors found that these staffing levels were not adequate to ensure the nurse administered the medications safely without interruption and to ensure residents had a choice in bedtimes.

**Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
The Person in Charge will review staffing levels in accordance with resident dependency and will restructure shifts accordingly to facilitate the medication round and residents' requirements and choices in the evening.

Nursing staff are wearing red aprons when on the medication round to highlight the need for no interruptions.

**Proposed Timescale:** 14/04/2015