

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Gormanston Wood Nursing Home
<b>Centre ID:</b>	OSV-0000131
<b>Centre address:</b>	Gormanston, Meath.
<b>Telephone number:</b>	01 841 4566
<b>Email address:</b>	gormanston@trinitycare.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Costern Unlimited Company
<b>Provider Nominee:</b>	Keith Robinson
<b>Lead inspector:</b>	Una Fitzgerald
<b>Support inspector(s):</b>	
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	89
<b>Number of vacancies on the date of inspection:</b>	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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**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 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:
19 September 2017 10:00	19 September 2017 18:30
20 September 2017 08:00	20 September 2017 14:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This report sets out the findings of an inspection carried out to inform a decision for the renewal of the centre's registration.

During the course of the inspection, the inspector met with residents and staff, the person in charge, the provider nominee and all members of the management team. The views of residents and staff were listened to, practices were observed and documentation was reviewed. Surveys completed by residents and their relatives or representatives were also reviewed.

The inspector found that care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The provider nominee and person in charge had proactively engaged with all stakeholders to ensure that the culture within the centre was open and transparent. The management team responsible for the governance, operational management and administration of services and resources demonstrated good knowledge and an ability to meet regulatory requirements.

The management and staff of the centre were striving to continuously improve residents' outcomes. A person-centered approach to care was observed. Residents appeared well cared for and expressed satisfaction with the care they received. There was good evidence that independence was promoted and residents have autonomy and freedom of choice. Residents spoke positively about the staff who cared for them.

The action plan from the last inspection November 2016 was followed up on. Overall, the inspector was satisfied that actions had been completed. However, the inspector was not satisfied that the new layout of furniture and fittings of one double room met the resident's needs. The available space was not sufficient to ensure that both resident's privacy and dignity could be respected at all times.

During this inspection moderate noncompliance was found in three of the nine outcomes inspected. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.

**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 Standards for Residential Care Settings for Older People in Ireland.**

***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):**

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

**Findings:**

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability, and the management team's roles and responsibilities for the provision of care are unambiguous. The centre promotes a culture of engagement with all stakeholders.

A comprehensive auditing and review system was in place to capture statistical information in relation to resident quality outcomes, operational matters and staffing arrangements. Clinical audits were carried out that analysed accidents, complaints, medicine management issues/errors, skin integrity, care plans, the use of restraint and infection control. This information was available for inspection. Policies and procedures were in place to guide practice and service provision.

The management support structure in place is comprehensive and the senior management team are actively involved in the running of the centre. There is a fortnightly meeting held with the provider nominee and the clinical operations manager. The centre is part of a group of nursing homes and the Directors of nursing within the group meet on a monthly basis. An annual review of the quality and safety of care delivered to residents for 2016 was completed that informed the service plan being implemented in 2017.

**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 centre was managed by a suitably qualified and experienced nurse. The person in charge was in position since the last registration inspection in the centre and held authority, accountability and responsibility for the provision of the service. The person in charge had followed up on the action plan from the last inspection and there was clear evidence of the positive impact this was having on the centre.

The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions and was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents. During the inspection she clearly demonstrated that she had sufficient knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre.

The residents and relatives spoken to throughout the two day inspection were knowledgeable about who the Director of nursing was and voiced that they would have no hesitation in bringing any issues to her attention. In addition the relatives voiced full confidence that any complaint made would be appropriately followed up.

**Judgment:**

Compliant

***Outcome 07: Safeguarding and Safety***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Measures were in place to protect residents from being harmed or abused. The policy

was reviewed April 2016 and it provided guidance for staff on the various types of abuse, assessment, reporting and management of allegations or incidents of abuse. Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. There were systems in place to ensure that allegations of abuse were investigated, and that pending such investigations measures were put in place to ensure the safety and welfare of residents. The training matrix evidenced that all staff had received training on Safeguarding Vulnerable Adults.

The inspectors saw that measures had been taken to ensure that residents were protected and felt safe while at the same time had opportunities for maintaining independence. There were enclosed gardens that residents could access at multiple locations. Communal areas in all units were accessible to residents. The inspector saw that there were facilities and equipment available to support residents to retain their independence. For example mobility aids, hand rails on corridors and circulating areas. There was a call bell facility in all rooms and within easy reach of residents. Residents told inspectors that they felt safe in the centre and spoke highly of the staff caring for them.

There was a system in place for the safeguarding of residents' finances and property. The provider was acting as a pension agent for a small number of residents. The monies were held in a separate account and the system in place to manage these payments was transparent and clear.

The systems in place to promote a restraint free environment in line with the national policy was described and demonstrated. A restraint policy last updated in May 2017 was available. The centre had a record of all restraint currently in use on each unit. Staff and records confirmed that in total ten of the 89 residents were using bedrails that restricted movement. The restraint policy clearly defined restraint and outlined the types of restraint, assessment, checks and review practices. The inspector reviewed files. A consent form was signed by the resident or next of kin. Care plans and evaluation records included evidence of alternatives available such as low low beds, bed bumpers, sensor alarms and crash mats. Records of the duration of restraint and safety checks or releases were recorded and evidenced by the electronic system in place.

The centre had a policy on and procedures in place to support staff with managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). This policy dated April 2017 was informed by evidence-based practice. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The inspector reviewed care plans including some for residents who had responsive behaviour. The care plans identified potential triggers and guided the clinical team on how best to manage any incidents. The guidance and system in place had templates of Activating Event, Behaviour and Consequences (ABC) assessment charts for recording any incidents. The inspector found that ABC charts were consistently updated when incidents occurred and this information was utilized by the multidisciplinary team to guide interventions. Referrals were also made to specialist psychiatry of older life when required. There was clear evidence that any advice given was acted on in a timely manner and improved outcomes for residents.

**Judgment:**

Compliant

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

Safe care and support

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

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

**Findings:**

The centre had policies and procedures relating to health and safety within the centre last reviewed in July 2017. There was a health and safety statement dated August 2017. The centre has a health and safety committee that meet monthly. The centre has a risk management policy last reviewed in July 2017 that includes items set out in Regulation 26(1). The centre had a current risk registrar that is kept under constant review on a monthly basis by the PIC. The register identified areas of risk within the centre and the control measures in place to minimise any negative impact on residents.

Arrangements are in place for investigating and learning from serious incidents/adverse events involving residents. The inspector reviewed the incident/accident log. The PIC carries out a monthly analyses of all incidents and all incidents are individually risk rated and signed off by the PIC.

Arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to personal protective equipment such as aprons and gloves, hand washing facilities and hand sanitisers on corridors. Staff were seen using these facilities between resident contact. Signs were on display to encourage visitors to use the hand sanitisers. Household staff spoken to were knowledgeable on the system in place to ensure that the cleaning regime minimises the risk of cross infection. The cleaning schedule included the routine daily chores but also contained detail of a deep cleaning schedule. The standard of cleanliness throughout the building was of a good standard.

Suitable arrangements were in place in relation to promoting fire safety. Fire safety and response equipment was provided. The fire alarm is serviced on a quarterly basis and the fire safety equipment is serviced on an annual basis. Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. All staff had received annual fire training. In addition staff spoken to were knowledgeable about fire safety and evacuation procedures. A detailed fire simulation fire drill was carried out on a monthly basis.

**Judgment:**

Compliant

***Outcome 09: Medication Management***

***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

There were written operational policies dated May 2017 relating to the ordering, prescribing, storing and administration of medicines to residents. Systems were in place for ordering, supply and dispensing methods. However, these policy documents had not been fully implemented as the inspector found unsafe practices in relation to the administration and recording practices of medicines for controlled drugs.

Residents were not sufficiently protected by medicine management practices found during this inspection and the standards did not meet with professional or regulatory requirements as follows:

- \*there was clear evidence in multiple medicine prescription kardexes that the general practitioner did not individually sign for medicines prescribed
- \*half of the volume of a controlled medicine ampule was administered to a resident and the inspector found the remaining volume drawn up and left in a medicine fridge for use at a later stage. The liquid within the syringe was not labelled and the ampule had been discarded to evidence what the liquid was.
- \*the controlled medicine log stock count records were not accurate. The documentation count stated there was eight ampules when there was nine in the box. The person in charge carried out an immediate review of the records on all four units. It was established that the extra ampule had been returned from another residents stock and not been recorded to allow for traceability by the clinical team.
- \*The double signing of the controlled register log to reflect that the count was inaccurate was not identified by the nursing team in the previous two counts.
- \*there was evidence that the centre had over reliance on a internal system of borrowing controlled medicines for the utilization by other residents and returning them at a later stage.

Audits of medication charts was carried out monthly by the person in charge. An external provider also carries out 3 monthly audits and the records were available for the inspector to review. The inspector reviewed the documentation on reported incidents. There was evidence that all incidents were reviewed by the person in charge and learning from incidents and reported errors informed improvements to protect residents.

Nursing staff were observed as they administered medications. Residents were

unhurried and reminded of the purpose of the medicines administered. Of the prescriptions reviewed the maximum dose of any medicine to be administered within a 24 hour period was recorded on all as required medicines.

A system was in place for a regular prescription review by the resident's general practitioner (GP) and pharmacist every three months

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

Residents' health care needs were met through timely access to medical services and appropriate treatment and therapies.

Access to a general practitioner and allied healthcare professionals including psychiatry of older life, physiotherapy, dietetic, speech and language therapy, dental, ophthalmology and specialist palliative care were made available when required. From the cases tracked it was evident that these services were available to some residents prior to their admission and as required thereafter. There was good evidence within the files that advice from allied healthcare professionals was acted on in a timely manner.

Pre-admission arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge visited prospective residents prior to admission. This arrangement gave the resident or their family an opportunity to meet in person, provide information and determine if the service could adequately meet the needs of the resident. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services.

Assessments and clinical care accorded with evidence based practice. Residents had been assessed to identify their individual needs and choices. The assessment process used validated tools to assess each resident's dependency level, risk of malnutrition, falls risk and their skin integrity. Clinical observations such as blood pressure, pulse and

weight were assessed on admission and as required thereafter. Each resident had a comprehensive care plan developed with 48 hours of admission. The care plans were person centered and the detail contained within the care plans evidenced that the staff were knowledgeable on the specific care needs of residents under their care. There was evidence that care plan reviews occur at intervals not exceeding four months or more frequently in consultation with either the resident or their representative.

There was evidence within one file that a resident had declined treatment. The potential negative impact of this decision had been explained by the nursing team and the resident understood this decision. The residents choice was supported and respected.

**Judgment:**

Compliant

***Outcome 14: End of Life Care***

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

There were policies dated April 2017 and procedures in place for end of life care which staff were familiar with. The inspector reviewed a number of residents end of life care plans and the detail contained within the files addresses the choice and wishes of residents and families. During the course of the inspection two residents had passed away. The inspector reviewed the care plan and facilities in place to ensure that residents receiving end of life care met their individual needs and wishes. Family and loved ones were facilitated to be with the resident when there were dying. All religious and cultural practices were facilitated.

**Judgment:**

Compliant

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

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

There was evidence of consultation with resident's and their representatives in a range of areas on a daily basis and a formal resident meeting is held monthly. The minutes for the past four months meetings were made available to the inspector. There was good resident attendance at the meeting and clear evidence that group and individual requests were acted upon.

Resident's have access to an independent advocacy services. There are currently four residents who are availing of this external service. The centre is part of the local community and residents have access to radio, television, newspapers, information and frequent outings to events. The activity programme within the centre had been reviewed and further developed by the activities team. The programme on display offered a wide variety of options for all residents. There was evidence of outings that had been organized and enjoyed by residents. The inspector was also informed of planned trips that are arranged for the coming weeks. There was evidence that residents have the opportunity to participate in activities that are meaningful and purposeful that suits their individual needs and interests.

The inspector found that there are adequate facilities for occupation and recreation including the opportunity to undertake personal activities in private. However, following on from the last inspection the management team had been actioned to review the design and layout of a twin bedroom within the centre. The inspector followed up on this action. The new layout of the room did not meet the needs of the residents that ensures they receive care in a dignified way that respects their privacy at all times.

During the inspection further reconfiguration and layout of the furnishings was trailed but the dignity and privacy of both residents continued to be compromised. In addition, there is no room for seating for both residents. This was discussed with the management team and a proposal to extend out the external wall and therefore enlarge the overall floor space of the room was suggested. This plan would then allow for appropriate space for screening and the ability to place seating within the room to accommodate both residents. The inspector informed the management team that the timeframe for when this plan would be completed needs to be stated within the action plan response.

**Judgment:**

Non Compliant - Moderate

***Outcome 18: Suitable Staffing***

***There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have***

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

**Theme:**  
Workforce

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

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

**Findings:**

The staff numbers in the centre were appropriate while the inspector was on-site. However, the inspector was not assured that the staffing levels at night were sufficient to ensure that the needs of residents were consistently met. The allocation of two nurses rostered for night duty was considered to be inadequate for 89 residents inclusive of a 19 bedded Dementia specific suite.

An actual and planned roster was made available to the inspector, which reflected the levels of staff on duty in the centre on the days of the inspection. The centre has four units and each unit has an allocated clinical nurse manager supported by day from the Director of Nursing and the Assistant Director of Nursing. The design and layout of the building is that each unit is self-contained and has a separate nurse station and clinical room.

The Inspector recommended a review of staffing skill mix on night duty for the following reasons:

- \* A number of relatives and a number of staff who spoke with the inspector expressed concerns about staffing levels at night, particularly whenever additional nursing interventions are required.
- \* A number of nursing staff voiced that at night time they were often under pressure to fulfil their nursing responsibilities such as administering medicines. Although this was not observed by the inspector on the days of inspection, the nursing staff informed the inspector that night time medicine medication rounds take two hours to complete. The inspector was informed that medication administration is regularly not completed until after 22.30 despite the start time of 20.00.
- \*The non compliance found during this inspection with Outcome 9 Medication Management.

In preparation for the inspection, relatives and some residents had completed a total of 23 questionnaires regarding the centre. Concern over night time staffing levels is voiced within the replies. Overall, respondents were complimentary regarding the management and staff team. In discussions with the inspector, relatives voiced concern over staffing levels at night and inadequate staff at mealtimes to attend to residents who required assistance to eat.

In general staff spoken to voiced that they had sufficient time to carry out their duties and responsibilities, and the management team explained the systems in place to supervise and appraise staff. Staff were seen to be supportive of residents and responsive to their needs. Requests and residents' alarm bells were responded to by staff in an acceptable timeframe.

All documents as required by Schedule 2 of the Regulations for staff were maintained and were made available for inspection. All staff nurses had up-to-date professional registration with An Bord Altranais agus Cnáimhseachais na hÉireann.

A mandatory and relevant staff training programme was in place and a record of training for all staff was available. Mandatory training such as moving and handling, fire training and the prevention, detection and management of abuse had been provided. Manual handling practices observed were safe and appropriate, with assistive equipment available for use.

The provider nominee and person in charge confirmed that all staff had completed Garda vetting in place. There were no volunteers working within the centre.

**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:***

Una Fitzgerald  
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<sup>1</sup>

<b>Centre name:</b>	Gormanston Wood Nursing Home
<b>Centre ID:</b>	OSV-0000131
<b>Date of inspection:</b>	19/09/2017 and 20/09/2017
<b>Date of response:</b>	17/10/2017

### 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 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:**

There were written operational policies dated May 2017 relating to the ordering, prescribing, storing and administration of medicines to residents. Systems were in place for ordering, supply and dispensing methods. However, these policy documents had not been fully implemented as the inspector found unsafe practices in relation to the administration and recording practices of medicines for controlled drugs.

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

Residents were not sufficiently protected by medicine management practices found during this inspection and the standards did not meet with professional or regulatory requirements as follows:

\*there was clear evidence in multiple medicine prescription kardexes that the general practitioner did not individually sign for medicines prescribed

\*half of the volume of a controlled medicine ampule was administered to a resident and the inspector found the remaining volume drawn up and left in a medicine fridge for use at a later stage. The liquid within the syringe was not labelled and the ampule had been discarded to evidence what the liquid was.

\*the controlled medicine log stock count records were not accurate. The documentation count stated there was eight ampules when there was nine in the box. The person in charge carried out an immediate review of the records on all four units. It was established that the extra ampule had been returned from another residents stock and not been recorded to allow for traceability by the clinical team.

\*The double signing of the controlled register log to reflect that the count was inaccurate was not identified by the nursing team in the previous two counts.

\*there was evidence that the centre had over reliance on a internal system of borrowing controlled medicines for the utilization by other residents and returning them at a later stage.

### **1. 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:**

All prescription kardexes will be reviewed and any kardexes that require individual signing will be signed by the relevant general practitioner.

A review of the unsafe practices found in relation to the administration and recording practices of medicines for controlled drugs will take place by the Director of Nursing and appropriate actions and learning highlighted.

All registered nurses will be required to repeat the medication management HSE Land training course and submit certificates to the Director of Nursing.

Specific external training in relation to administration and recording practices of controlled medicines will be mandatory and provided to all registered nurses in house.

**Proposed Timescale:** 31/10/2017

## **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:**

Following on from the last inspection the management team had been actioned to review the design and layout of a double bedroom within the centre. The inspector

followed up on this action. The new layout of the room did not meet the needs of the residents that ensures they receive care in a dignified way that respects their privacy at all times.

**2. 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:**

A review of the room took place by the provided nominee, PIC and Facilities manager and a plan of works drawn up to complete the modifications necessary to ensure the design and layout of the room meets the needs of the residents.

The first phase will ensure the permanent restructuring of the room as shown to the inspector on the second morning of the visit. All electrical works will take place, followed by the repositioning of the privacy rails. A full redecoration of the room will take place followed by the repositioning of the beds and furniture. This will be completed by 31/10/17

The second phase will be the further modification of the window area to ensure the layout of the room meets the needs of the residents. This will be completed on the 22/12/17

Proposed Timescale: Phase 1; 31/10/17 Phase 2; 22/12/17

**Proposed Timescale: 22/12/2017**

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

The staff numbers in the centre were appropriate while the inspector was on-site. However, the inspector was not assured that the staffing levels at night were sufficient to ensure that the needs of residents were consistently met. The allocation of two nurses rostered for night duty was considered to be inadequate for 89 residents inclusive of a 19 bedded Dementia specific suite.

An actual and planned roster was made available to the inspector, which reflected the levels of staff on duty in the centre on the days of the inspection. The centre has four units and each unit has an allocated clinical nurse manager supported by day from the Director of Nursing and the Assistant Director of Nursing. The design and layout of the building is that each unit is self-contained and has a separate nurse station and clinical room.

The Inspector recommended a review of staffing skill mix on night duty for the

following reasons:

\* A number of relatives and a number of staff who spoke with the inspector expressed concerns about staffing levels at night, particularly whenever additional nursing interventions are required.

\* A number of nursing staff voiced that at night time they were often under pressure to fulfil their nursing responsibilities such as administering medicines. Although this was not observed by the inspector on the days of inspection, the nursing staff informed the inspector that night time medicine medication rounds take two hours to complete. The inspector was informed that medication administration is regularly not completed until after 22.30 despite the start time of 20.00.

\*The noncompliance found during this inspection with Outcome 9 Medication Management.

### **3. 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 current staffing levels in the home are in line with the assessed needs of the residents using the modified Barthel Dependency and the Staffing guidance for Residential Care Homes June 2009, however a review of the staffing skill mix will take place for night duty and changes made if appropriate.

A meeting will take place with all nursing staff to discuss the best use of resources to ensure that night staff don't feel under pressure in fulfilling their nursing responsibilities such as administering medicines and feel supported to carry out their duties.

**Proposed Timescale:** 31/10/2017