

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Raheen Community Hospital
Centre ID:	OSV-0000611
Centre address:	Tuamgraney, Scariff, Clare.
Telephone number:	061 923 007
Email address:	marissa.butler@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Mark Sparling
Lead inspector:	Mary Moore
Support inspector(s):	Paul Dunbar
Type of inspection	Announced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	1

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 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:
27 January 2015 09:30	27 January 2015 19:30
28 January 2015 09:00	28 January 2015 19:00

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

Outcome 01: Statement of Purpose
Outcome 02: Governance and Management
Outcome 03: Information for residents
Outcome 04: Suitable Person in Charge
Outcome 05: Documentation to be kept at a designated centre
Outcome 06: Absence of the Person in charge
Outcome 07: Safeguarding and Safety
Outcome 08: Health and Safety and Risk Management
Outcome 09: Medication Management
Outcome 10: Notification of Incidents
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This inspection was the sixth inspection of the centre by the Authority. There were twenty four residents living in the centre with a range of care requirements including respite, long term and palliative.

The inspection process entailed inspectors meeting and speaking with staff, residents and relatives. Inspectors reviewed documents required to be in place and available for inspection including policies and procedures, clinical records, staff related records, complaints records, health and safety and fire safety related records. Inspectors inspected all areas of the premises.

Prior to the inspection residents and relatives/carers were also requested to complete a questionnaire on a voluntary basis regarding their experience of the centre; eleven completed questionnaires were returned, six from relatives/carers and five from residents three of which were completed with assistance. The feedback received in the questionnaires was consistently positive and this would concur with the feedback received by inspectors from residents and relatives during the course of the inspection. One resident and the majority of relatives did articulate concerns in relation to the future of the service and the proposed development plans. 50% of relatives who completed questionnaires expressed concerns (based on their observations) in relation to the available staffing levels and associated their concern with the high needs of the residents and a recent depletion in staffing numbers.

There was evidence of good practice. Residents had daily access to medical care and good access to other healthcare professionals such as physiotherapy. A day care service was affiliated to the centre and inspectors saw how more independent residents enjoyed mingling with the day care service users or participating in the activities provided there. There was evidence of improvements made in quality of life outcomes for residents such as the rescheduling of meal times, the appointment of an activities co-ordinator and regular consultations with residents as to the organisation of the service.

There was evidence of some environmental refurbishment works completed, works were on-going and plans for the redevelopment of the premises to address the major non compliance with regulatory requirements were on display and reported to be in progress.

Overall however the inspection findings were not satisfactory. Eighteen regulatory outcomes were inspected and the provider was judged to be in compliance with two, in substantial compliance with two, in moderate non-compliance with six and in major non-compliance with eight. There was an identified nursing deficit in the service of 2.5 whole time equivalents and this included a senior nurse manager the CNM2. The findings to support the judgements are discussed in detail in the body of the report and the failings and the action to be taken by the provider to address the failings are listed in the action plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. 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.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose dated January 2014 contained most of the information required by required by Schedule 1 of the regulations. It did not however reference; the current governance structure of the centre; the provider's criteria for accepting emergency admissions if any; the arrangements for the management of the centre in the absence of the person in charge.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The agreed local management structure of Director of Nursing (DON), Clinical Nurse Manager 2 (CNM2) and Clinical Nurse Manager 1 (CNM1), in descending order of responsibility and accountability was not in place following the departure of the CNM2 in late 2014 to take up another post. Inspectors were not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored. The inspection

findings and levels of non-compliance evidenced in some outcomes reflect this and also indicate that lines of authority, accountability and responsibility were not clear. This was discussed in detail with the management team at verbal feedback; the finding was not disputed.

There were formal systems in place for reviewing and monitoring the provision of care and services and there was evidence of improvements made. For example the centre was participating in a practice development initiative and reported and evidenced improvements included more person centred mealtimes and the introduction of an activities co-ordinator.

The person in charge reported directly to the nominated provider and reported that they met formally on a monthly basis.

Completed audits included hand hygiene practice, risk management compliance, medication documentation audits and the review of falls; the overall recorded level of compliance achieved was high. However, these inspection findings also support and as discussed in the relevant outcomes, that the system of review was not always relevant or sufficient to identify deficits in care and practice.

Judgment:
Non Compliant - Major

Outcome 03: Information for residents

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

Theme:
Governance, Leadership and Management

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

Findings:
The centre had a resident's guide which was made available at the main foyer of the building. Residents had an agreed written contract with the provider. The inspectors reviewed a sample of the contracts and found that they contained all of the required information in terms of the services provided to residents and the responsibilities of the provider towards the residents' care. Each contract was signed by the resident or their next of kin and also by a representative of the provider. The contracts set out the fees which were to be charged to residents.

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 had been in post since November 2012. She was suitably qualified and experienced and worked full-time in the centre Monday to Friday. The person in charge was a registered general and psychiatric nurse; there was evidence of her ongoing professional development to advanced nurse practitioner level in dementia care. The person in charge was currently undertaking a leadership programme with the royal college of surgeons.

The person in charge had overall responsibility, authority and accountability for the care and services provided; the person in charge was also responsible for the day care service affiliated to the centre. There were systems in place for the exchange of information between staff and the person in charge including information on occupancy and dependency levels, admissions and the restraint log; the person in charge also attended the daily verbal handover. Inspectors found that the person in charge was fully informed as to some aspects of the care and services provided such as staffing, health and safety, risk management and the refurbishment works. However, gaps were also evident and the person in charge did not have all of the information required to allow her to exercise all of her statutory obligations. Inspectors were not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored. This is actioned under Outcome 2; Governance and Management.

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):

No actions were required from the previous inspection.

Findings:

The centre maintained a range of records on site which were easily retrievable. However, there were some gaps evident in the documentation.

All of the policies required by the Regulations under Schedule 5 were present apart from one i.e. there was no policy for the handling and disposal of unused or out of date medication. This will be discussed further under Outcome 9: Medication Management. The centre retained a copy of all of the notifications sent to the Authority under Regulation 31. However, the inspectors noted records of incidents/accidents which should have been reported and were not. This will be discussed further under Outcome 10: Notification of Incidents.

There were gaps identified in some of the records pertaining to staff. One of the staff files did not contain a photograph. A number of the staff did not have evidence of up-to-date registration with their relevant professional organisation. The person in charge informed inspectors that this was due to an ongoing national industrial relations issue.

There was a record of all visitors to the centre which was available at the entrance. There was clear signage requesting that visitors sign in and sign out. There was a directory of residents maintained by the centre. This directory did not contain all of the information as required by the Regulations. For example, there were some entries where the next of kin details were incomplete. There was no record of the residents' general practitioner and their contact details. Furthermore, there was no recording of patient transfers to other designated centres or hospitals and no recording of the time, date and cause of death of any resident who died while living at the centre.

The centre had up-to-date insurance which provided adequate cover for accidents or injury to residents, staff and visitors.

Judgment:

Non Compliant - Moderate

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:

Staff spoken with confirmed that there had been no absence of the person in charge of a duration that required notification to the Chief Inspector.

The agreed local management structure of Director of Nursing (DON), Clinical Nurse Manager 2 (CNM2) and Clinical Nurse Manager 1 (CNM1), in descending order of responsibility and accountability was not in place following the departure of the CNM2 in late 2014 to take up another post. Inspectors were not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored.

Judgment:

Non Compliant - Major

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:

There was a suite of policies in place with a protective component including the wider organisations policies and procedures on the management of any suspected, alleged or reported abuse; evidence based and nationally agreed policies on the use of restraint and procedures for the management of behaviours that challenged.

Protection training had been provided to staff in 2013 and in 2014. Staff spoken with confirmed their attendance at training and said that they had never seen any behaviours or attitudes that placed residents at risk of harm or abuse. There was evidence that the provider exercised its responsibility and responded in line with the policy in response to any alleged abusive behaviour. The feedback received from residents and relatives spoken with and surveyed was consistently positive.

Staff had not received training on identifying, understanding and responding to behaviours that challenged. Staff spoken with reported that no resident presented with challenging behaviours but this did not equate with some clinical records seen or the fact that 30% of residents had a current prescription for antipsychotic medication.

Restrictive practices were in place in the form of bedrails and a resident alarm system to alert staff when a resident assessed as at risk moved beyond the exit door. The number

of bedrails in use had increased from the time of the last inspection. Eleven sets of bedrails were now in use and records seen and staff spoken with indicated that they were generally conceptualised as an enabler. Records seen indicated that the use of bedrails was informed largely by the concept of “enabler” and “resident choice” rather than policy. The process of risk assessment was not robust; the tool in use was cumbersome and not always fully and accurately completed. The tool in use for the resident alarm was a tool to be used to inform the requirement for a therapeutic plan to enable safe mobilisation, not specifically to support the use of the alarm; there was no evidence of a therapeutic plan detailing alternatives or other support and safety measures such as meaningful engagement or supervised walks.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There were reasonable measures in place to promote and protect the health and safety of residents, staff and visitors.

There was an organisational and a centre specific health and safety statement in place. The risk register was dynamic in that it contained risk assessments for standard potential risks such as slips, trips and falls but also risk assessments for new and evolving risks such as deficits in staffing or risks associated with the ongoing environmental refurbishment works. There was documentary evidence that relevant personnel from within the wider organisation worked with the person in charge on identifying and implementing the required controls. At the time of inspection the risk register contained eleven “open” risks to be dealt with as part of the overall development plan such as remedial works to the car park which was seen to be in very poor condition. Inspectors were satisfied that the person in charge had knowledge and oversight of the open risks.

The risk register contained risk assessments for the risks identified in article 26(1) (c).

Likewise there was documentary evidence that fire safety improvement works were required and these were scheduled to be completed on a phased basis in line with the refurbishment works. The required works were outlined in a comprehensive inspection report from the local fire authority dated December 2013. The person in charge confirmed and inspectors saw that some works were completed and documentary evidence was provided to support ongoing implementation and monitoring of the

outstanding works by relevant persons including the organisations fire and safety officer.

A fire register was maintained and in it there was documentary evidence that all fire equipment was inspected and tested at the prescribed intervals. The fire detection system was most recently serviced in November 2014; fire fighting equipment and the emergency lighting in February 2014. Further records seen indicated that there were in house procedures for the routine checking of fire equipment such as the fire detection system and fire escape routes. Fire action notices and diagrammatic fire evacuation plans were prominently displayed as were fire warning break glass units. Staff spoken with confirmed their attendance at fire safety training including simulated fire evacuation exercises. There was a centre specific fire plan and the knowledge conveyed by staff concurred with the plan for progressive horizontal evacuation. However, there was a lack of clarity as to the frequency, content, outcome and any required learning from the fire evacuation exercises/drill with only one recent record of a drill convened on December 2014 seen.

There were measures in place for infection prevention and control. Observation audits of hand hygiene practice had been completed in 2014 with satisfactory compliance evidenced. Staff had ready access to personal protective equipment and were seen to access it as required. Staff designated wash-hand basins had been provided on circulation areas.

There was a comprehensive emergency plan available to staff outlining the contingencies in place for responding to a range of potential emergencies such as loss of power, fire, evacuation or communications failure; a generator was available on site.

Staff were seen to be provided with a high specification of equipment for moving techniques in resident care including ceiling hoists. Records seen indicated that the equipment was inspected and tested in November 2014. However, training records seen did not support that all staff had received the required training within the mandatory timeframes.

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

Findings:

Inspectors were concerned that some aspects of medication management practice, including controlled drugs lacked robust review and oversight to ensure that processes were in line with current guidelines and legislation.

There were policies and procedures in place relating to the ordering, prescribing, storing and administration of medicines. The policy on the supply of controlled drugs (MDA's) stated that the MDA could be obtained from either a pharmacist or from a wholesale supplier on a resident specific basis. The inspector was not satisfied that practice in relation to obtaining MDA's was in adherence with legislative requirements. Staff confirmed that some stock was obtained from a wholesale supplier but the only person holding authority under the regulations to lawfully obtain the MDA (the Director of Nursing (DON)/ Person in Charge) was not aware of this arrangement. The requisition order on foot of which the MDA's had been supplied was not available for inspection; there was a record of delivery in December 2012 and November 2013. It was not clear why this arrangement was necessary as a pharmacist was ordinarily responsible for the dispensing and supply of medications to the centre which may under the relevant legislation negate the authority of the DON. In effect there were two systems in place for sourcing MDA's; one on an individual named resident prescription basis and the other generic wholesale supply. The relevant body (Pharmaceutical Society of Ireland 2014) would state that this would be considered poor practice and difficult to assure (as identified by this inspection) the necessary accountability for the drugs concerned as required under the law.

A controlled drug register was maintained but the stock balance seen (12) for one drug did not match that seen on the delivery records (11).

All controlled drugs in stock were not labelled with resident specific details.

The pain management policy referenced the still valid World Health Organisation (WHO) 1986 three step analgesic ladder. Its recommendations particularly in relation to trialling a mild opiate did not concur with the pain management practice described by staff.

Records seen and staff spoken with confirmed that 30% of extended care residents had a regular prescription for antipsychotic type medication. There was a formal system in place for the multi-disciplinary review of medications but a sample reviewed (25%) indicated that no change was required to the prescribed medication regime. This did not concur with other medical records seen and did not reassure the inspector as to the effectiveness of the review process.

While staff spoken with said that all unused or unwanted medications were returned to the pharmacist on a regular basis there was no explicit policy or procedures in place including signed and verified records of all such returns.

Each resident had a signed and dated prescription and administration record. Medical authorisation was in place for any medication required in an altered format (crushed). The maximum dosage of PRN medications (medications not scheduled or required on a regular basis) was stated. Medications were securely stored and a fridge was available for items requiring refrigeration; the temperature was monitored daily. The inspector

reviewed a 20% random sample of administration records and noted no medication administration errors or omissions as identified at the time of the last inspection.

Judgment:
Non Compliant - Major

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:

The inspectors found that there were some incidents/accidents recorded at the designated centre that had not been notified to the Authority as required by Regulation 31. There may have been some lack of clarity as to what constituted a notifiable event and this was discussed and clarified such as the detection of legionella. However, the centre maintained an incident and accident book which was reviewed by the inspectors and this and other records seen indicated that were clear events that should have been notified to the Chief Inspector but which were not. There was a record of a resident leaving the centre without the knowledge of the staff; the resident was discovered on the grounds of the centre and was assisted back inside by staff.

There were a number of instances where residents in the centre had wounds or pressure sores which would be categorised as 'Grade 2+'. Restrictive practices were also noted to be in use and not notified to the Authority. For example, bedrails were in place for a number of residents in the centre. Staff informed inspectors that these were used as 'enablers' and at the residents' request. However, the Authority requires that their use is recorded and reported by the designated centre in their quarterly returns when the resident of their own volition cannot remove the device

Judgment:
Non Compliant - Major

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):

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

Findings:

Twenty four residents were living in the centre, fifteen of whom were in receipt of extended care; 13 residents had been assessed by staff using a validated tool as of maximum dependence in their care needs.

The inspector saw that residents had very good access to medical review and care. A local general practitioner (GP) was appointed to the service as Medical Officer and medical review was available to each resident on admission and as required on a daily basis if necessary. Residents admitted for shorter periods of time were also medically reviewed on admission. Records seen by the inspector confirmed regular and timely medical review in line with the residents changing needs. There was evidence of other health promoting measures such as seasonal flu vaccination and regular blood profiling as an adjunct to monitoring well being and the efficacy of treatment regimes. Some residents also choose to participate in the "healthy eating club" and enjoyed healthy dietary choices.

There was evidence to support that residents had responsive access to other healthcare professionals including speech and language therapy, occupational therapy, chiropody and dietetics. A physiotherapist attended the day service twice weekly and also attended to the needs of the residents in the centre as requested. Optical and dental services were available locally and staff confirmed that if necessary transport was provided via the day care bus as it was wheelchair accessible. The inspector also saw that as appropriate to their needs residents were facilitated to have ongoing access to personnel from the psychiatric services.

There were records in place to support that all relevant information about a resident was obtained by the centre from the discharging service or hospital.

The inspector saw that each resident had a nursing plan of care based on an assessment of resident's strengths and need for supports. Each assessment was supported by a range of validated assessment tools. Plans of care were in place where supports had been identified as required. However, based on the sample of care plans seen by inspectors there were gaps and inconsistencies that did not assure that nursing care was at all times evidence based. This was particularly noted in relation to the identification, grading, management and ongoing monitoring of wounds; staff spoken with said that only one current staff member had wound care education and training.

As discussed in Outcome 15; food and nutrition, recommendations based on expertise of other healthcare professionals were incorporated into the nursing plan of care but it was of serious concern to inspectors that one recommendation was retracted based on

nursing opinion without discussion and consultation with the other discipline.

Judgment:

Non Compliant - Major

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:

As identified on all previous inspections elements of the design and layout of the premises are not suitable for its stated purpose and function, do not meet the individual and collective needs of residents, and do not meet regulatory requirements.

There was evidence of completed and ongoing refurbishment works. Upgrading works to the first floor administration and staff area were substantially complete and a new treatment/clinical room was operational on the ground floor. Plans for the development of the premises to address regulatory non-compliance were on display, planning permission was reported as imminent and project timeframes were drafted; however there was no explicit time-bound and costed plan available as required by the Authority.

Resident private accommodation was provided in four single bedrooms, three with full en-suite sanitary facilities, one with en-suite toilet and wash-hand basin. The remaining residents were accommodated in multi-occupancy rooms of four, five (two rooms) and seven occupants. The multi occupancy rooms appeared to be of sound construction and were in good decorative order but presented challenges to the provision of adequate space, privacy and dignity for each resident.

The communal space provided was inadequate and consisted of two separate conservatory type structures; one clinical area opened directly into one of these areas.

The available dining space was inadequate for the number and needs of the residents accommodated.

The main entrance was seen to be used as a designated smoking area.

Ordinarily a sufficient number of baths and showers were in place for the number of residents accommodated. However, inspectors noted that only one shower and one bath were in proper working order on the day of inspection and as these were both in the same room this effectively meant that only one bath/shower was available for twenty one residents; twenty two if the centre was at full occupancy. It was not clear as to how long this significant deficit had been in place and when it was to be rectified.

While adequately equipped the design, layout and general presentation of the laundry was poor. Given the location of equipment there was no clear delineation between a clean and soiled area for the segregation of linen. There was evident defective infrastructure with exposed electrical and pipe work.

Residents were seen to be provided with suitable aids, appliances and equipment to support and promote their comfort and well-being and records were in place for the maintenance of such equipment.

The premises were found to be clean and bright, adequately heated and ventilated.

The kitchen was organised, suitably and sufficiently equipped and reported by staff to be monitored by the relevant Environmental Health Officer (EHO).

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

Findings:
The inspectors found a number of issues in relation to the management and recording of complaints.

There was a complaints policy in place and the procedure was available in a number of prominent places in the centre. However, there was conflicting information in these notices. For example, the complaints officer referred to on one of the notices was a person who no longer worked in the service. Furthermore, the notice in one area of the centre gave details of a contact for appeals which was different to that referenced in another notice.

The person in charge was the nominated complaints officer for the centre. A nurse manager was the second complaints officer. However, the person in charge was also identified as the designated person to ensure all complaints were appropriately responded to and recorded.

The inspectors reviewed a number of complaints which were documented in the centre's complaints log. There were two complaints which were fully and properly recorded and followed the registered provider's procedure for handling complaints. The inspectors had concerns regarding the handling of a third complaint. The documentation of this complaint was not as thorough as other complaints in the records. For example, there was insufficient detail on the resolution of the complaint. In addition, inspectors were not satisfied that the complaint was handled in such a way as to ensure the complainant or other similar complainant would be comfortable making a complaint in the future.

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):

No actions were required from the previous inspection.

Findings:

The provider offered a dedicated palliative care and end of life care service. Two suites were available each comprising of a single en-suite bedroom with an adjoining living/kitchenette area. Staff spoken with said that given the predominance of multi-occupancy rooms all residents had access to these suites for end of life care so as to afford privacy and dignity to the resident and extended family unless there was an expressed choice to remain in the multi-occupancy room.

Two staff had completed post graduate education in palliative care and a significant number of staff had completed the end of life programme "what matters to me".

Staff spoken with said that care was supported by specialist palliative care services; however they also said that access and review following referral to the service was not always facilitated in a timely manner. There was no clear rationale provided for this deficit in access and this requires further exploration by the provider to ensure that access to specialist palliative care services is available when assessed as appropriate to a residents needs.

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):

No actions were required from the previous inspection.

Findings:

All meals were prepared freshly on site daily. The inspector saw adequate and varied stocks of fresh, dry and frozen foodstuffs. There was a menu in place that offered choice at each mealtime and staff were seen to ascertain each resident's individual meal preference. The meals served were seen to concur with the menu, portion sizes were adequate, meals were appealingly presented and residents were seen to enjoy their meals. There were formal systems of communication between clinical and catering staff and the records seen specified each residents likes and dislikes and any specific dietary requirements such as diet of a modified consistency. Catering staff spoken with had a clear understanding of the required interventions. However, the evening meal option for residents requiring diet of a modified consistency was noted to lack a hot/savoury option with an over reliance on milk puddings and yogurt based products.

The person in charge reported that resident mealtimes had been altered to ensure that a reasonable timeframe was now provided between each main meal. This was evident on inspection and inspectors also noted that residents were offered fluids and snacks between meals. The person in charge was currently co-ordinating the installation of a system to ensure that there was easy and ready access to a supply of fresh drinking water at all times.

Processes were in place to ensure that residents did not experience poor nutrition and/or hydration; these included monitoring of body weight, the completion of a validated nutrition assessment tool, good referral and access to other healthcare professionals including speech and language therapy and dietetic services and the implementation of daily intake records where a concern was identified.

However, despite the substantial evidence of good practice it was of serious concern to inspectors to see documentary and physical evidence that the recent speech and language instructions for one resident (made on the basis of an assessment of risk of aspiration) were knowingly deleted from the plan of care and not implemented in practice. While a nursing opinion was offered for this decision (risk of dehydration) this was not documented, the decision was not evidence based and was not made in consultation with and following discussion with the appropriate health professional so as

to ensure the residents safety. The person in charge was at verbal feedback requested to address this deficit in care with immediate effect.

The main dining area was not sufficient to accommodate the number of residents in the centre with more dependent residents seen to take their meals where they were seated either in the conservatory or in the bedrooms. This obviously impacted on the social dimension of meals. Staff were seen to provide assistance appropriately, adaptive cutlery was in use and some family members were also seen to be present at mealtimes; those spoken with confirmed that this was their choice. There is a deficit in the current staffing levels and given the dependency levels of residents inspectors noted that staff were busy at mealtimes both supervising and providing assistance with some residents meals seen to be in place before staff assistance was available. However, it was also noted that two staff nurses were both engaged in medication administration at this time; both the number and deployment of staff at mealtime requires review.

Judgment:

Non Compliant - Major

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspectors were satisfied that residents were consulted in the organisation of the centre and participated in activities which were meaningful and appropriate to their needs and interests.

The centre had an activities coordinator who worked on a part-time basis. This staff member described the range of activities provided in the centre including: flower arranging, bingo, card making and various other arts and craft activities. The centre had recently begun to receive weekly visits from a local youth group and the residents had made a plan for activities with this group for the coming weeks.

Residents were consulted in the operations of the centre. There were regular residents' meetings and inspectors viewed the minutes of these meetings. Items discussed included the plans for renovation of the centre, the introduction of a mobile shop and the provision of equipment for making tea and coffee. Resident involvement in the decoration of the centre was actively encouraged by staff. For example, residents were

invited to select new table cloths for the dining area.

The residents were facilitated with religious services at the centre twice a week. The inspectors observed staff assisting residents in preparing for this service on the morning of inspection. Residents who were not in a position to attend the service could listen to the proceedings via a speaker system. The centre made provision for voting to take place on site and had a list of residents who were registered to vote. There was an advocacy service available to residents and the contact details for this service were displayed in a prominent place.

The inspectors observed a number of residents meeting with visitors throughout the inspection period. All of the relatives of residents who spoke with inspectors stated that visitors were also facilitated and made to feel welcome by staff. Residents also had access to a private telephone. However, there was no room available should residents wish to meet visitors in private and the facilities that could be made available as reported by relatives and staff such as the main dining room (when not in use) or the living room annex of one of the palliative care suites were unsuitable.

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):

No actions were required from the previous inspection.

Findings:

The centre had effective systems in place to safeguard residents' personal property and possessions. On admission, each resident's belongings were recorded and this record was signed by the resident and a staff member. The record detailed items of clothing, jewellery, furniture and electronics etc. Residents who purchased or received items while living in the centre had these added to the record.

Clothing was protected by using an 'iron on' label which stated the person's name. The staff member with responsibility for the laundry service was clear on the processes surrounding the management of residents' clothing.

The inspectors found that very few residents were engaged with the management of their own finances. Staff informed inspectors that there was one resident who would occasionally request money from the provider for personal use. The manner in which this was handled was cumbersome and did not readily enable the resident to retain

control over their own finances. Residents had access to a shop on site carrying items such as soft drinks and toiletries. Staff informed inspectors that it was largely respite residents that availed of this facility and that long-stay residents at the facility would usually receive money from family or relatives in order to purchase items. This practice did not maximise residents' independence and choice.

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):

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

Findings:

Based on the providers own process for identifying staffing numbers and skill mix, and a nursing deficit identified by this process, inspectors were not satisfied that the centre had sufficient staffing levels/skill mix to meet the health and social care needs of residents at all times. The person in charge informed inspectors that she had identified a deficit in nurse staffing levels of 2.5 whole time equivalents. This assessment was carried out using a recognised objective staffing tool. Inspectors also noted that staff were quite busy at all times but particularly at mealtimes. For example, it was observed that there was only one staff member present in a room where four residents required full assistance with their meal. The identified deficit also included the CNM2 position and the impact of this deficit has been discussed in Outcomes 2,4 and 6.

Staff records were reviewed by the inspectors and found to have deficiencies; these are discussed earlier in Outcome 5: Documentation to be kept at a designated centre. Staff who spoke to inspectors confirmed that they had received recent training in fire safety, manual handling and elder abuse but this was not reflected in the documentation regarding staff training. Based on the training records seen on inspection the record for manual handling training stated that only seven staff had undertaken the training; the provider later advised that further records of completed training were maintained but not presented for the purpose of inspection.

As mentioned in Outcome 7: Safeguarding and Safety, only one staff member had received training in behaviours that challenge; this is a mandatory requirement under the Regulations. A deficit was also identified in wound prevention and management training with only one staff member reported to have completed such training.

Staff meeting minutes were available for inspectors to review. Items that were discussed include the plans for the extension works to the centre, annual leave, industrial relations and ongoing regulatory issues. The records suggested that while staff meetings did take place, they were of an irregular nature.

There was a planned and actual rota. There was evidence in the rotas to demonstrate that adequate cover was provided for multi-task attendants during periods of annual and sick leave.

Judgment:
Non Compliant - Major

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:

Mary Moore
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Raheen Community Hospital
Centre ID:	OSV-0000611
Date of inspection:	27/01/2015
Date of response:	24/02/2015

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The statement of purpose contained most but not all of the required information.

Action Required:

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

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

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

- The Organisational chart in Statement of Purpose has been updated to reflect changes.
- Information regarding emergency admissions and the management of the centre in the absence of the person in charge is now included in the Statement of Purpose.

Proposed Timescale: 24/02/2015

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Inspectors were not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored.

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:

- There is an Interim Governance plan in place since 16.02.2015.
- The permanent CNM2 post was advertised on the 29.01.2015. Interviews scheduled for week commencing 02/03/15

Proposed Timescale: 30/06/2015

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:

The directory of residents did not contain all of the required information.

Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

- A new Directory of Residents has been put in place taking into account all of the information required by the regulations. This will be implemented by the 06.03.2015.

Proposed Timescale: 06/03/2015

Theme:

Governance, Leadership and Management

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

Some staff records did not include all of the information as required by Schedule 2 of the Regulations i.e. a photograph and a record of current registration details of professional staff.

Action Required:

Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.

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

- All staff files have been reviewed and there is an up to date photograph of every staff member on file as at 16.02.2015.
- All staff files have been reviewed and have documentary evidence of NMBI 2014 registration. The P.I.C. has requested that each R.G.N. complete a Patient Safety assurance Certificate by the 30.04.2015.

Proposed Timescale: 30/04/2015

Outcome 06: Absence of the Person in charge

Theme:

Governance, Leadership and Management

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

The agreed local management structure of Director of Nursing (DON), Clinical Nurse Manager 2 (CNM2) and Clinical Nurse Manager 1 (CNM1), in descending order of responsibility and accountability was not in place following the departure of the CNM2 in late 2014 to take up another post. Inspectors were not satisfied that the management systems in place were sufficient to ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored.

Action Required:

Under Regulation 33(1) you are required to: Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the

matters contained in Regulation 33(2).

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

- There is an Interim Governance plan in place since 16.02.2015.
- The permanent CNM2 post was advertised on the 29.01.2015. Interviews scheduled for week commencing 02/03/15.

Proposed Timescale: 30/06/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Staff had not received training on identifying, understanding and responding to behaviours that challenged.

Action Required:

Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

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

- Training for staff will be provided by 30/04/15

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:

The number of bedrails in use had increased from the time of the last inspection. The process of risk assessment was not robust; the tool in use was cumbersome and not always fully and accurately completed. There was no evidence of a therapeutic plan detailing alternatives or other support and safety measures such as meaningful engagement or supervised walks.

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:

- Nursing staff will review all residents with bed rails in situ and will explore alternatives.
- Measures will be put in place to record who continue to have bed rails in situ as per policy.

Proposed Timescale: 31/03/2015

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

There was a lack of clarity as to the frequency, content, outcome and any required learning from the fire evacuation exercises/drill with only one recent record of a drill convened on December 2014 seen.

Action Required:

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

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

In future all documentation in relation to fire drills will be expanded to incorporate all the information required by the regulations. The December 2014 report has been updated (17.02.2015) to incorporate the above. A record of the fire evacuation/drill which occurred on the 23rd of January 2015 has also been documented.

Proposed Timescale: 24/02/2015

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:

Staff said that all unused or unwanted medications were returned to the pharmacist on a regular basis but there was no explicit policy or procedures in place including signed and verified records of all such returns.

Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance

with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

Documentation has been put in place to record all unused or unwanted medications. The medication management policy now reflects what actions are required to deal with unused or unwanted/out of date medications as at 18.02.2015

Proposed Timescale: 18/02/2015

Theme:

Safe care and support

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

The inspector was not satisfied that practice in relation to obtaining MDA's was in adherence with legislative requirements and relevant guidance. In effect there were two systems in place for sourcing MDA's; one on an individual named resident prescription basis from the pharmacist and the other generic wholesale supply.

A controlled drug register was maintained but the stock balance seen (12) for one drug did not match that seen on the delivery records (11).

All controlled drugs in stock were not labelled with resident specific details.

There was a process for the review of medications but records seen did not reassure the inspector as to the effectiveness of the review process.

Pain management practice described by staff did not concur with policy.

Action Required:

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

- All medications in future including MDAs will be dispensed from the local pharmacist for each resident and will be labelled accordingly. R.G.N.s continue to record MDA stock levels mornings and evenings i.e. change of shift. Ongoing quarterly audits will take place.
- Drugs are no longer being supplied by a generic wholesale supply. There is only one source in the supply of medication to Raheen CNU and that is from the local pharmacy.
- The P.I.C. met with the Medical Officer on the 16.02.2015 to discuss the findings in this current report regarding the multi-disciplinary medication reviews and the importance of recording any changes in both the medication booklet and the medication review form.
- Training will be organised for staff to assist them in implementing current policy to

enhance the pain management experience for residents.
•The local pharmacy supplier was contacted and the vials of morphine were returned on the 17.02.2015

Proposed Timescale: 30/06/2015

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

Incidents, serious injuries and restrictive practices recorded at the centre were not notified to the Authority.

Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

Following the Inspection the three NF03 notifications in relation to wound care management have been sent to the Chief Inspector. The NF05 notification in relation to a resident leaving the centre was sent to the Chief Inspector since the Inspection.

Proposed Timescale: 24/02/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

There were gaps and inconsistencies in some nursing documentation that did not assure that nursing care was at all times evidence based. This was particularly noted in relation to the identification, grading, management and ongoing monitoring of wounds; staff spoken with said that only one current staff member had wound care education and training.

Recommendations based on expertise of other healthcare professionals were incorporated into the nursing plan of care but it was of serious concern to inspectors that one recommendation was retracted based on nursing opinion without discussion and consultation with the other discipline.

Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

- Wound care training has been arranged for the nursing staff which will take place on the 27.02.2015 and 13.03.2015.
- Arrangements are underway to address the matter of the retraction of the recommendation of the Healthcare professional.

Proposed Timescale: 31/03/2015

Outcome 12: Safe and Suitable Premises**Theme:**

Effective care and support

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

As identified on all previous inspections elements of the design and layout of the premises are not suitable for its stated purpose and function, do not meet the individual and collective needs of residents, and do not meet regulatory requirements.

Only one shower and one bath were in proper working order on the day of inspection and as these were both in the same room this effectively meant that only one bath/shower was available for twenty two residents.

The design, layout and general presentation of the laundry was poor. Given the location of equipment there was no clear delineation between a clean and soiled area for the segregation of linen. There was evident defective infrastructure with exposed electrical and pipe work.

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:

- There was a sign in place stating that one shower was out of order, however this was inaccurate. This sign should have been removed on the week beginning 12.01.2015. An interim measure had been put in place while the shower was out of order. The bath and shower facilities in the day centre were and are available to the residents.
- In October 2014 a plan had been devised to separate the room containing the shower and bath. Work commenced on this on the 21.01.2015 and will be completed by the 28.02.2015.
- On the day of the inspection, the covering around the electrical and pipe work had

been removed to fire proof these and this work was completed on the 12.02.2015.
•Planning approval has been granted. Tenders for the work will be issued by end of March 2015. Building to commence Summer 2015.

Proposed Timescale: Summer 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:

Complaints were not fully and properly recorded.

Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

- The documentation in relation to the handling of the third complaint has been updated to reflect more accurately the events pertaining to the management of the complaint. This was completed on the 16.02.2015.

Proposed Timescale: 16/02/2015

Theme:

Person-centred care and support

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

The person in charge was a designated person to deal with complaints. This person was also nominated as having responsibility for ensuring complaints and appropriately responded to and recorded.

Action Required:

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

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

- All notices in relation to complaints and the contact for appeals have been updated. This was completed on the 17.02.2015.

Proposed Timescale: 17/02/2015

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:

Staff spoken with said that care was supported by specialist palliative care services; however they also reported that access and review following referral to the service was not always facilitated in a timely manner.

Action Required:

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

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

- An audit of access / support services following referral to specialist palliative care services in Raheen CNU will be completed on review of the records of the past six months.

Proposed Timescale: 31/03/2015

Outcome 15: Food and Nutrition

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 documentary and physical evidence that the recent speech and language instructions for one resident (made on the basis of an assessment of risk of aspiration) were knowingly deleted from the plan of care and not implemented in practice.

Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

- The issue raised during the inspection was addressed immediately following the feedback. The instructions for this resident were as per the Speech & Language Therapist recommendations. The Speech & Language Therapist was contacted to review the resident. Revised instructions were given over the telephone and the resident was reviewed by the Speech & Language Therapist on the 17.02.2015.

Dysphagia training has been arranged with the Speech & Language Therapist for Tuesday, February 24th, Wednesday, March 4th and Wednesday, March 11th 2015

Proposed Timescale: 11/03/2015

Theme:

Person-centred care and support

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

There is a deficit in the current staffing levels and given the dependency levels of residents inspectors noted that staff were busy at mealtimes both supervising and providing assistance with some residents meals seen to be in place before staff assistance was available

Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

- Residents that require assistance with meals are assisted at 8.15; 12:30 and 17:00 where staff make themselves available to assist residents. This will be reviewed on an ongoing basis as it depends on the number of residents who require assistance.
- Protected mealtimes will be implemented from the 26.02.2015.

Proposed Timescale: 26/02/2015

Outcome 16: Residents' Rights, Dignity and Consultation

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 has no space available for residents to meet with visitors in private.

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:

- Phase one of the development plan has made provision for a visitors room.
- Tenders will be issued by end of March 2015. Construction to commence Summer 2015. Estimated completion of Phase 1 of the construction is June 2016.

Proposed Timescale: 30/06/2016

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 were not facilitated to retain control and have access to their personal finances.

Action Required:

Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

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

- A review of resident finances is been carried out at present and a processes will be put in place for residents to access their finances.

Proposed Timescale: 31/03/2015

Outcome 18: Suitable Staffing

Theme:

Workforce

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

There were insufficient numbers of nursing staff to meet the needs of residents and ensure the effective governance of the centre.

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:

- On day 1 of the Inspection, 1 CNM1 and 3 RGN's were on duty.
- On day 2 of the Inspection, 1 CNM1 and 2 RGN's were on duty. The absence of 1 RGN on the second day arose because of a maternity leave absence which could not be filled by the nursing agency.
- Since the 16th February, 2105 the CNMII vacancy has been filled on a interim basis pending the permanent filling of the position following public advertisement in January, 2015.

Proposed Timescale: 30/06/2015

Theme:
Workforce

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

Deficits were identified in the staff training programme.

Action Required:

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

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

- Manual handling training for all staff is scheduled to take place in May 2015. The P.I.C. is awaiting dates for the training planner at present.

Proposed Timescale: 31/05/2015