

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sancta Maria Nursing Home
Centre ID:	OSV-0004589
Centre address:	Parke, Kinnegad, Meath.
Telephone number:	044 937 5243
Email address:	sanctamarianh@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Compóird Teoranta
Provider Nominee:	Compord Teoranta
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	30

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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
22 November 2017 07:30	22 November 2017 17:30
23 November 2017 07:30	23 November 2017 15:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of a two- day unannounced, triggered inspection following receipt of unsolicited information of concern received by the Health Information and Quality Authority (HIQA). However , the inspector found no evidence during this inspection to substantiate these concerns. The inspector also followed up on notifications, including notifications recently provided to HIQA in relation to an unexplained absence of a resident from the centre. The inspector also monitored progress on the actions required arising from the previous inspection on 24 July 2017 and found that all these actions had been completed.

The inspector met with residents, relatives, the provider representative, the director of healthcare services, the person in charge, the Assistant Director of Nursing (ADON) and staff members during the inspection. The inspector observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident and or incident logs

The inspector saw that residents' healthcare needs were met and they had access to appropriate medical and allied healthcare services. The atmosphere within the centre was homely, comfortable, in keeping with the statement of purpose and assessed

needs of the residents who lived there. Overall, the inspector found the staff team, the person in charge and provider representative were committed to providing a good quality service for residents that was homely and person-centred. However, there were considerable improvements required in relation to the overall governance and management of the centre, health and safety issues and to ensuring safe medication management.

The centre had recently increased significantly in size with an additional 33 beds, and the provider representative acknowledged that this expansion had been a challenge for management and staff. The provider representative gave the inspector assurances that this challenge was being monitored and managed closely with the support of the senior management team. The provider representative also stated that there would be additional senior management resources provided to support the existing governance in the centre and an additional healthcare manager would be working closely with the existing management team to ensure effective improvements.

From the eight outcomes reviewed during this inspection, two outcomes were compliant and, two outcomes were deemed to be substantially compliant. Three outcomes were found to be moderately non-compliant: governance and management; medication management; and safeguarding and safety. Significant risks were identified on this inspection and the outcome on health and safety and risk management merited a judgment of major non-compliance. Evidence of compliance is discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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

No actions were required from the previous inspection.

Findings:

All actions from the previous inspection had been fully completed. There were management systems in place to ensure that the service provided was monitored and safe. Clear lines of accountability and authority were evident in the centre. A regional manager who attended the centre on a weekly basis provided direct support to the person in charge. The person in charge stated that this manager was readily available to support her. Staff to whom the inspector spoke with confirmed that there was always a manager on call in the centre and they knew who was available each day and night. The inspector noted from a review of the staff duty roster that the on-call arrangement was clearly recorded and that such managerial support was shared among the person in charge, the Assistant Director of Nursing (ADON) and the Clinical Nurse Manager (CNM) throughout each week. A monthly meeting was held with the regional manager, person in charge and key personnel in the centre, for example, the ADON, CNM, housekeeping staff and a representative from the nursing and care team. This meeting discussed the overall running of the centre and looked at clinical, managerial and environmental issues. Minutes were available of these meetings and an action plan was developed to address any issues identified. The inspector found that key aspects of the service and key clinical parameters were audited including resident falls, complaints, person-centred care standards and risks. This process was supported by an electronic data management system which was readily accessible to the provider representative and all members of the management team. Data collated was analysed and action plans were developed to inform areas requiring improvement. An annual review of the quality and safety of care delivered to residents was available.

There was evidence of good consultation with residents and their relatives. All residents and visitors with whom the inspector spoke with stated that they were happy with the service provided and they were kept well informed. Residents appeared well cared for and were very complimentary of the care and support they received from staff. Many residents were able to self-advocate and were complimentary of the staff and the

person in charge. Residents told the inspector that they felt safe living in the centre and well supported by staff and management. Adequate resources were available to meet the needs of residents, such as adequate nursing and healthcare staff, sufficient assistive equipment and facilities. The overall atmosphere in the centre was welcoming, and it was warm, bright, clean and well ventilated on both days of inspection. However, the inspector formed the view that the management systems required improvement to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This view was evidenced by the findings of this inspection and in particular by the following:

- The centre had been moving away from compliance as evidenced by non-compliances identified in the three inspections of this centre in 2017, two of which were triggered inspections following receipt of unsolicited information of concern.
- Recently recruited nurses were rostered to work on night-duty. These nurses had mainly acute hospital experience from a different jurisdiction. They had limited experience in older-person care and no specific training in dementia care or responsive behaviours (a term used to describe how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
- Inadequate details were provided in a recent notification to HIQA in relation to an allegation of abuse of a resident.
- Inadequate health and safety arrangements were identified on this inspection, particularly the intermittent unimpeded access to the centre in the context of a recent unexplained absence of a resident from the centre.
- There was a failure to securely store a week's supply of medications for one respite resident.

The inspector noted that the centre had been significantly extended earlier in the year with an increase from an original 43-bedded centre to a 78-bedded centre. On the second day of this inspection, the provider representative acknowledged that this increase of an additional 35 beds, as well as the subsequent increase in the size and layout of the premises, had presented significant challenges. The provider representative gave the inspector assurances that these challenges were being monitored and managed closely with the support of senior management. The provider representative also stated that additional senior management resources would be made available to support the local management team, including the support of an additional healthcare manager who would be working closely with the existing management team in the centre.

Judgment:

Non Compliant - Moderate

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

<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The person in charge had been appointed to this post in December 2005 and worked full-time in the centre. She was a nurse with good experience in the area of nursing of the older person. During the two days of the inspection, the person in charge demonstrated adequate knowledge of the legislation and of her statutory responsibilities. She was clear in her role and responsibilities as person in charge and displayed a commitment towards providing a person centred quality service. She was fully engaged in the governance and administration of the centre on a consistent basis. She met regularly with residents and their representatives, the members of the management team, the care staff and nursing staff. Minutes were maintained of these meetings. Residents, spoken with, described the person in charge as very supportive and staff also described her as a 'very approachable' manager.</p> <p>The person in charge had completed a postgraduate management qualification. The person in charge was supported by the assistant director of nursing, a healthcare manager and the provider representative. In addition, there was a clinical nurse manager, staff nurses, an activity coordinator, carer staff, catering, household, laundry and maintenance staff.</p>	
<p>Judgment: Compliant</p>	

<p><i>Outcome 07: Safeguarding and Safety</i> <i>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.</i></p>		
<p>Theme: Safe care and support</p>		
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Shortly before this inspection, HIQA had received notification from the centre in relation to an allegation of abuse which was then being investigated. The provider representative informed the inspector during this inspection that a full investigation was being conducted and the report into this allegation would be provided to HIQA as soon as possible.</p> <p>The inspector found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed demonstrated an adequate understanding of safeguarding and prevention of elder abuse. All staff spoken with were clear about their responsibility to report any concerns or incidents in relation to the protection of a</p>		

resident. There were suitable policies and procedures in place to guide staff in the care and protection of residents. For example, there was a policy on safeguarding and the detection, management and prevention of elder abuse, and a policy on the use of restraint. Each of these policies was recorded as being reviewed in August 2017. Safeguarding training was provided to most but not all staff. Refresher training was provided on an ongoing basis in-house. Staff training records and interviews with staff provided evidence that most but not all staff had received up-to-date training in a programme specific to protection of older persons. In addition, some of these staff had recently been recruited from a different jurisdiction, working with reduced support (on night duty) and had limited experience of care of older persons.

The centre maintained day-to-day expenses for a small number of residents and the inspector saw evidence that adequate financial records were maintained. All lodgements and withdrawals were documented and were signed for by staff members. The inspector noted that there were 10 residents with a diagnosis of dementia and a number of other residents with varying levels of cognitive impairment living in the centre. There was a policy on the management of responsive behaviours (a term used to describe how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) that had been most recently reviewed in August 2017. However, staff was not provided with training in the management of behaviours or with dementia-specific training. The absence of this mandatory training combined with a lack of suitable clinical experience of some staff was of concern to the inspector and was therefore also referenced under Outcome 2 of this report.

There was evidence that those few residents who presented with behaviours that challenge were reviewed by their general practitioner (GP) or referred to other professionals for full review and follow up as required. Care plans reviewed by the inspector for residents exhibiting responsive behaviours were seen to include positive preventative and management strategies. These were clearly outlined in residents' care plans and therefore ensured continuity of approach by all staff using person-centred de-escalation methods.

There was a policy on restraint which had been updated in August 2017. There was evidence that the use of restraint was generally in line with national policy. The restraint register recorded five residents using bedrails and three residents had wandering bracelets on the days of the inspection. For all residents with any form of restraint, there was evidence that there was regular checking/ monitoring of residents, discussion with the resident's family and the GP. The inspector saw that there was an assessment in place for the use of restraint, which identified what alternatives had been tried to ensure that the particular form of restraint was the least restrictive method to use. The inspector was assured by the practices in place and saw that whenever possible alternative measures were used. For example, there were low-low beds and alarm mats used for a number of residents to reduce the use of bedrails in the centre.

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:

A recent notification had been received by HIQA in relation to an unexplained absence of a resident from the centre. The provider representative informed the inspector that the provider-led investigation report was near completion and would be provided to HIQA the week following this inspection. However, on the first morning of this inspection at 07.20am, the inspector was able to walk into the centre unimpeded and found that the main entrance door was not locked. In the context of a recent notification received by HIQA in relation to an unexplained absence of a resident, this unsecured access to the centre was a significant concern to the inspector. The inspector noted that a number of staff arriving at the centre shortly after he did in fact have to enter a keypad code to enter the centre. The person in charge immediately arranged for this door lock to examine by electrical engineers.

A written report was subsequently provided to the inspector in relation to this review which stated that the magnetic locking device on the entrance door was found to not be engaging properly and the lock had been repaired. The inspector was also able to access the treatment room on the main corridor and found a week's supply of one resident's medications stored in an unlocked cupboard in this treatment room. The inspector requested that the person in charge investigate this matter and to immediately put suitable arrangements in place to ensure that this situation would not reoccur. The inspector noted that the person in charged did put suitable arrangements in place to secure this door lock, including increased monitoring checks and review of all exit doors into the centre. In addition, the person in charge confirmed that this matter would be investigated. These issues were also discussed under Outcome 2 and Outcome 9 of this report.

There was a risk management policy as set out in Schedule 5 of the regulations and included all of the requirements of Regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the centre which covered, for example, risks such as residents' falls, fire safety risks and manual handling risks. There was a centre-specific safety statement, and the inspector was informed that the healthcare manager and or the provider representative and the person in charge met each month to review health and safety issues including any incidents, accidents or near misses in the centre. This meeting also reviewed procedures and practices including risk management and fire safety in the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency and assessments for pressure ulcer formation.

All accidents and incidents were recorded in the computerised care planning system and submitted to the person in charge, the healthcare manager and provider representative. The inspector noted that there was evidence of suitable actions in response to individual incidents. There was recorded information and communication with relevant persons such as the person in charge, the residents' GP, next of kin, the clinical observations taken and any learning or changes required to prevent reoccurrence. However, the hazard identification process required improvement as a number of potential hazards were identified by the inspector that required action including:

- the intermittent unrestricted access to the centre required review, particularly in the context of the recent unexplained absence of a resident from the centre
- the unrestricted access to two sluice rooms was potentially hazardous to any resident with a cognitive impairment and required review
- the lack of storage racks in one sluice room potentially compromised the prevention of cross-contamination practices
- the unrestricted access to the kitchen staff changing room had not been risk assessed
- the risk assessment for the enclosed garden areas required review to ensure that all risks were assessed including the height of the boundary wall
- there were no call-bells available in the oratory room or the multipurpose room and this required review to ensure compliance with regulations
- the use/ application of wandering bracelets required review to ensure their effectiveness in the context of 10 out of the 14 exit doors not having any wandering alarm device fitted.

Systems were in place for the assessment, planning, implementation and review of healthcare risks. This included nursing assessments, care plans and clinical risk assessments such as a wandering assessment and a missing person profile for any residents considered at risk of an unexplained absence from the centre. However, the level of risk assessment in relation to a resident's unexplained absence from the centre required improvement for the following reasons:

- The inspector noted from the 48 residents living in the centre that only three had a wandering assessment and or a missing persons profile completed.
- In the context of 10 residents with a diagnosis of dementia and some with responsive behaviours and a number of other residents with varying levels of cognitive impairment living in the centre
- This view was also informed by the intermittent unrestricted access to the centre and the recent notification of an unexplained absence of a resident from this centre.

This issue is also addressed under Outcome 11 of this report.

There were fire safety policies and procedures that were centre-specific. The fire safety plan was viewed by the inspector and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. The inspector examined the fire safety register which detailed services and fire safety tests carried out. Fire fighting and safety equipment had been tested in July 2017, the fire alarm was last tested in November 2017 and the emergency lighting was last tested in August 2017. In addition, there were records of weekly fire alarm and emergency lighting and daily monitoring of fire exits. The person in charge outlined how fire evacuation drills were practised every Monday in the centre. However, the records of these fire evacuation drills were not adequate for the following reasons:

- The fire evacuation drill records did not record the fire scenario being simulated during

<p>the fire drill.</p> <ul style="list-style-type: none"> ● The fire evacuation drill records did not include the length of time taken for each practice. Hence areas for improved evacuation times could not be identified. ● The fire evacuation drill records did not record any problems or deficiencies identified during the fire drill. <p>In addition, there were the following fire safety issues identified on this inspection:</p> <ul style="list-style-type: none"> ● The wooden floor in the smokers' room required a risk assessment to ensure its suitability for its stated purpose. ● There were door wedges in fire doors in the door into the reception and the person in charge's office. ● The smoking risk assessment record required review to clearly demonstrate the rationale for the quantification of identified risks associated with a resident smoking. ● The storage of lighters and matches in some residents' bedrooms required a risk assessment to ensure the suitability and or safety of this arrangement. <p>An outside fire safety instructor provided fire safety training, with the most recent training recorded showing this was training was last provided in November 2017. All staff spoken with demonstrated an appropriate knowledge and understanding of what to do in the event of fire. However, two staff spoken with stated that they had not participated in a fire evacuation drill in the centre. The person in charge informed the inspector that she would ensure that all staff had such training as soon as possible.</p> <p>The inspector noted that copies of each resident's personal emergency evacuation plan (PEEP) were stored in each resident's bedroom. The person in charge outlined how these documents were made readily available to support staff in managing any emergency situation involving a resident in the centre. Each staff member spoken with was familiar with these PEEPs and the individual evacuation requirements of residents. However, the PEEP records viewed required improvement to include the residents' level of understanding of fire detection and of the fire alarm sounder. In addition, these records did not contain details regarding the residents' level of supervision when brought to a place of safety following evacuation.</p>	
<p>Judgment: Non Compliant - Major</p>	

<p><i>Outcome 09: Medication Management</i> <i>Each resident is protected by the designated centre's policies and procedures for medication management.</i></p>		
<p>Theme: Safe care and support</p>		
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: On the first morning of this inspection, the inspector was able to walk into the centre</p>		

unimpeded and access the treatment room which contained a week's supply of one resident's medications that were unsafely stored in an unlocked cupboard in this treatment room. This unsecured access to residents' medications was a significant concern to the inspector. The inspector requested that the person in charge investigate this matter and to immediately put suitable arrangements in place to ensure that access to all medications would be suitably restricted. The inspector noted that the person in charge did put suitable arrangements to secure access to residents' medications. This issue was also discussed under Outcome 2 and Outcome 8 of this report.

There was a centre-specific medication policy which was dated as having been reviewed most recently in April 2017. Medication management training had been provided to nursing staff. There were records of medication competence assessments having been completed by recently recruited nursing staff in 2017. There was a community retail pharmacy that supplied medication and supported the centre by providing a pharmacist who visited to conduct medication audits. Nursing staff with whom inspectors spoke with demonstrated adequate knowledge of the general principles and responsibilities of medication management. Nursing staff with whom the inspector met with outlined a robust procedure for the ordering and receipt of medicines in a timely fashion.

Medication administration practice was observed by the inspector. Nurses while administering medications were observed adopting a person-centred approach. For example, when administering medication, staff were observed interacting with each resident in a supportive and considerate manner; speaking to residents and asking for feedback prior to administering medication. Aside from the aforementioned unsecured medications, all other medicines were stored in a locked cupboard, medication trolley or within a locked room only accessible by nursing staff. Medicines requiring refrigeration were stored securely and appropriately. There were measures in place for the handling and storage of controlled drugs that were in accordance with current guidelines and legislation. Controlled drugs were also recorded as administered in the medication administration records in accordance with guidance issued by An Bord Altranais agus Cnáimhseachais na hÉireann. The temperature of the medication refrigerator was noted to be within an acceptable range, and the temperature was monitored and recorded daily.

Compliance aids were used by nursing staff to administer medicines. A sample of medication prescription records was reviewed and each medication prescription was reviewed by the residents' GP every four months or more often, if required. There was no nurse transcription of medication prescriptions. However, from a sample of medication administration records reviewed, the inspector noted a number of medication administration records contained gaps where the administering nurses' initials were required. These gaps in administration records meant that it was not clear on these occasions if the resident actually received their medication or not. From the sample of medication administration records seen, the inspector noted that such gaps were recorded in at least three different residents' medication administration records.

Given that the issue of unsecured access to one resident's medications informed a judgment of major non-compliance under Outcome 8, a judgment of moderate non-compliance was merited for this outcome.

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:
 HIQA had received unsolicited information of concern. However, there was no evidence identified on this inspection to substantiate these concerns.

The inspector was satisfied that residents' healthcare requirements were met to an adequate standard. The inspector attended the morning staff hand-over meetings on both days of this inspection. The inspector noted that the staff nurse on night duty gave updates on all residents' care and support needs from the previous night to incoming day shift staff nurses and healthcare staff. There was a prepopulated hand-over record used by staff to ensure an accurate hand over occurred. This record promoted resident safety by reducing the potential for errors in communication and provided incoming care staff with relevant residents' information. However, the inspector noted that a copy of this hand-over sheet which recorded some personal information on residents was stored on the counter at one of the nurses' stations and therefore these personal and or health-related details may have been visible to anyone passing this counter. The storage of these records on the nurses' counter was not adequate as it potentially compromised residents' privacy in relation to their health and support care needs. This issue was actioned under Outcome 16 of this report.

Residents had good access to GP services. There was evidence of regular reviews of residents' overall health on admission and on re-admission following return from acute hospital care, and as required when clinical deterioration was noted. The person in charge outlined how the centre had an electronic-based care recording system. The inspector observed staff inputting records of ongoing care provision using touch screens that were located in a number of areas in the centre. The inspector saw that residents had a comprehensive nursing assessment completed following admission. The assessment process involved the use of a variety of validated tools to assess each resident's risk of deterioration. For example, risk of malnutrition, falls, level of cognitive impairment and pressure related skin injury among others.

There was evidence of access to specialist and allied healthcare services to meet the care needs of residents. For example, speech and language therapist (SALT), psychiatry, opticians, dentists and chiropody services. Access to palliative care specialists, dietician and on-site physiotherapy were also available. On the second day of the inspection the inspector observed the physiotherapist working and supporting residents in the centre. Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments. From a review of care plans, there were details to support staff in effectively managing residents' health problems. The person in charge and the assistant director of nursing closely monitored the care planning system to ensure that residents' support and care needs were met. The person in charge and the assistant director of nursing regularly reviewed care plans to ensure appropriate care provision. The inspector found that the care plans were person-centred and individualised. Nursing staff and healthcare assistants spoken with were familiar with and knowledgeable regarding residents up-to-date needs.

Assessments and care plans were reviewed four-monthly or more frequently as required. A daily nursing record of each resident's health, condition and treatment given was maintained and those records seen by the inspector were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. Systems were in place for the assessment, planning, implementation and review of healthcare needs. This included nursing assessments, care plans and clinical risk assessments such as a wandering assessment and a missing person profile for any residents considered at risk of an unexplained absence from the centre. However, the level of risk assessment in relation to a residents' unexplained absence from the centre required improvement and this issue was actioned under Outcome 8 of this report.

All residents had been risk assessed in relation to their risk from falls. The level of falls in the centre was reviewed regularly by the person in charge, Assistant Director of Nursing and staff at regular care staff meetings to promote the reduction in the incidence of falls within the centre. This meeting also reviewed any other such incidences of slips, trips or near misses in the centre. All incidences of falls were reviewed individually to identify any possible antecedents or changes and or learning that could be obtained to prevent any re-occurrence. Subsequently, measures were identified in residents' falls prevention care plans, and there were also reassessments of falls risks by staff after each fall. The inspector was satisfied that overall care plans contained few identified deficiencies between planned and delivered care. Residents and their representatives to whom the inspector spoke with were complimentary of the care, compassion and consideration afforded to them by staff.

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

While some residents clearly had a high level of health and support needs, a number of residents required minimal level of assistance from staff. Many residents were able to self-advocate and the inspector noted that a number of residents had retained a high level of independence. For example, one resident informed the inspector that they "pretty much did" their "own thing most days", that staff completely respected their choice in how they spent the day. The resident said staff were there if and when needed. This resident outlined a busy weekly schedule, including visits to friends and family members and going for trips to local events. All visitors that the inspector met with stated that their loved one was well care for and that they could visit them at any time. One visitor described how their parent had lost their mobility following an episode of illness and that the staff had supported their parent to regain their mobility through intensive intervention and support over a protracted period. The visitor was very complimentary of the ongoing care that staff provided.

There was evidence that residents were consulted with and participated in the organisation of the centre. Overall, residents' rights, privacy and dignity were respected during personal care, when delivered in their own bedroom or in bathrooms. A number of residents spoken with also confirmed that they were afforded choice in relation their daily lives and, for example, could receive visitors in private. There were no restrictions to visiting in the centre and the inspector observed several visitors at different times throughout the two-day inspection. There was a visitor record book available near the entrance to the centre and the inspector noted that some but not all visitors had signed this record. The person in charge agreed to review these arrangements to encourage more visitors to sign the visitor record. While residents' rights, privacy and dignity were respected, improvement was required in relation to the storage of the prepopulated hand-over sheets, as mentioned under Outcome 11 of this report. These sheets recorded some personal information of residents and were stored on the counter at one of the nurses' stations. This potentially compromised some residents' privacy in relation to their health and support care needs.

Residents' right to choice and control over their daily life was also facilitated in terms of times of rising and returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Documentary evidence that residents and relatives were involved and included in decisions about the life in the centre was viewed. Regular meetings were held where residents were consulted through the residents' committee meetings. The most recent residents' committee meeting was recorded as occurring in August 2017. The inspector noted a large number of residents attended this meeting. The person in charge and the activities coordinator met regularly to review any issues raised at the residents' committee meetings. There was evidence of

<p>changes having been made as a result of these meetings. For example, there had been issues about choice of meals, the heating in one room and request from a resident for repair of equipment. All these issues were recorded as being discussed with the person in charge and actioned accordingly. Feedback and suggestions from these meetings were recorded with an action plan with time frames.</p> <p>A programme of varied internal activities was in place for residents. Information on the day's events and activities was prominently displayed in the centre. Residents informed the inspector that they enjoyed music sessions and particularly outside music performances in the centre. The inspector was told that residents' spiritual needs were met. For example, the rosary was provided every Tuesday by two volunteers and Mass was celebrated by the local priest once a month in the centre. The inspector was informed that any other religious denominations were catered for as necessary and the local Church of Ireland clergy also visited regularly.</p> <p>There was Closed Circuit Television (CCTV) cameras in place in a number of locations in the centre and there was a centre-specific policy for their use. However, the inspector requested the provider representative to review all CCTV cameras in the centre to ensure that none potentially compromised the privacy and dignity of residents. For example, the inspector noted that there were CCTV cameras located in the activities room, the smokers' room, in sitting rooms and the lobby area near the main entrance to the centre, where some residents spent time sitting chatting or reading their newspapers during the day.</p>	
<p>Judgment: Substantially Compliant</p>	

<p><i>Outcome 18: Suitable Staffing</i> <i>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.</i></p>	
<p>Theme: Workforce</p>	
<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: An actual and planned roster was maintained in the centre. The inspector noted that the person in charge worked full-time and was available Monday to Friday. There was also an assistant director of nursing available during the week to support the person in</p>	

charge in her role. In addition, there was a clinical nurse manager who worked in the centre. There were staff nurses on duty both in the daytime and at night-time that were assigned to the two sections of the centre. The inspector spoke to nurses on both day and night duty shifts and attended the hand-over meeting in both sections of the centre over the two days of the inspection. The inspector observed practices and spoke with care staff, the person in charge, the assistant director of nursing, staff nurses, the director of care services and the provider representative.

Residents spoke very positively about staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. Staff demonstrated a good understanding of their role and responsibilities to ensure appropriate delivery of person-centred care to residents. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their likes and dislikes. A number of visitors stated that their relative was well cared for and they were very happy with the services provided. Some visitors stated that they always felt very welcome in the centre and it was clear to the inspector that some visitors were well known to staff.

From speaking to the person in charge, staff, clinical nurse manager, assistant director of nursing and a review of documentation, staff appeared to be supervised appropriate to their role and responsibilities. Staff induction and appraisals were in place for all staff. Recently recruited staff told the inspector that this process was in place and a review of a sample of staffing records by the inspector concurred with this. The person in charge discussed staffing issues with the inspector, and suitable protocols and records were seen to be in place where any concerns had been identified. There was an education and training programme available to staff. The training matrix indicated that most mandatory training was provided and staff had attended training in areas such as manual handling and the prevention, detection and management of elder abuse. However, these training records indicated that many staff had not completed training in responsive behaviours. This issue was identified and actioned under Outcome 7 of this report. There were a number of residents suffering from a diagnosis of dementia and other residents with cognitive impairments. However, the inspector noted that many staff had not completed training in dementia care.

Inspectors reviewed a sample of staff files which included all the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2017 for nursing staff were seen by the inspector. The provider representative confirmed that all staff and volunteers had been suitably Garda vetted.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Vincent Kearns
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:	Sancta Maria Nursing Home
Centre ID:	OSV-0004589
Date of inspection:	22/11/2017
Date of response:	15/12/2017

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

To put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

1. 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

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

monitored.

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

The Person in Charge (PIC) is supported by an Assistant Director of Nursing (ADON), who is responsible for the quality and safety of clinical care in the centre.

The PIC reports directly to a regional Healthcare Manager, who visits the centre regularly and provides advice and support regarding the overall management of the centre and monitors regulatory compliance.

Additional support will be provided by a Healthcare Manager in Quality, Safety and Risk; she will provide training and education to nurses and care staff on a range of topics, including Safeguarding Vulnerable Persons, Dementia Care, responsive behaviours, risk assessment and effective clinical documentation. She will analyse work flows and advise on appropriate staff allocation and prioritisation of workload in the context of working in a newly extended facility. She will implement systems to ensure that all new staff receive effective induction to the environment, including medication management competency assessments, mandatory training and she will work alongside the PIC and ADON, assisting and guiding them in evaluating the performance and practice of staff, ensuring that appropriate interventions are made to support staff to become proficient and safe practitioners appropriate to their role. This work, once safely embedded in the culture of the home, will be continued by the ADON and monitored by the PIC.

Staff who have recently been recruited will not be rostered to night duty until such time as they have completed induction, a mandatory training programme and the PIC determines that they are competent and capable in all aspects of their role.

The PIC completes a weekly report, outlining all aspects of quality, safety, capacity and capability in the centre. Any anomalies are investigated and resolved.

A monthly management team meeting is held in the centre, attended by the Healthcare Manager, chaired by the PIC and including a member of each department in the centre. The agenda of the meeting is to review the quality and safety of the centre; staff are informed about developments, their views and suggestions are welcomed and they have an opportunity to actively contribute to quality improvement initiatives in the centre. An Action Register is documented and updated at each meeting, including a progress review on identified actions.

A detailed review of a specific aspect of quality and safety is undertaken each quarter at this meeting; for example, a strategy for prevention and management of falls or a review of residents with unsafe wandering tendencies; and a plan to improve resident safety will be discussed.

An annual review of Quality and Safety will be undertaken in January 2018; following this a broad strategy to improve quality and safety in the centre in the coming year will be determined.

Health and safety arrangements are being reviewed regarding entry and exit points to ensure that access to the building is suitably secured and that the security of all occupants is maximised.

The door to the main entrance to the centre has been serviced and repaired.

Access to medication and clinical treatment rooms is restricted to nurses.

All residents' medications are stored securely in accordance with the centre's policies and procedures and legislative requirements regarding safe storage of medicinal products.

There are regular spot checks and monitoring of building security by the local management team in the centre.

All notifications to the Authority will be completed and submitted in accordance with regulatory and legislative requirements. They will include relevant and comprehensive information as required and an outline of actions taken, in order to reassure the Authority that the care of all residents in the centre is safe and effective.

Proposed Timescale:

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:

To ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

2. 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:

All staff in the centre will receive education and training in the care of a resident with a diagnosis of dementia and in managing responsive behaviours. All staff who have already received this training will receive refresher sessions to ensure that their skills and knowledge are up to date and consistent with the centre's policy on caring for people with dementia and responsive behaviours

Proposed Timescale: 31/01/2018

Theme:

Safe care and support

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

To ensure staff are trained in the detection and prevention of and responses to abuse.

3. Action Required:

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

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

All staff in the centre will receive education and training in Safeguarding Vulnerable Persons at Risk of Abuse and they will be able to recognise and report any suspicions of abusive behaviour appropriately. Staff will also receive regular refresher training sessions on protection of residents from abuse in the centre.

Proposed Timescale: 31/03/2018

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified. Systems were in place for the assessment, planning, implementation and review of healthcare risks including assessments such as a wandering assessment and a missing person profile for any residents considered at risk of an unexplained absence from the center.

4. Action Required:

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

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

The Registered Provider has provided assurance to the Authority that the Main entrance door has been secured; the centre can be accessed by staff and designated visitors by using a keypad, otherwise a bell is used to permit entry.

The Person in Charge (PIC) has increased monitoring checks and reviewed all unsecured entrances and exits. All exit points apart from the front door will be fitted with an alarm that will sound each time the doors is opened.

All medications will be stored and secured appropriately, in accordance with the centre's policy on safe storage of medication and legislative and regulatory requirements.

All nursing staff will receive Medication management training on HSEland as part of induction and a Medication Competency Assessment will be undertaken with each qualified nurse before he/she is deemed competent to administer medication without direct supervision.

Medication administration charts and prescriptions will be regularly monitored and audited to ensure that they are documented correctly, that the prescriber's instructions are adhered to and that there are no signature omissions. If a resident does not receive a medication for any reason, the reason for this will be documented on the medication administration chart.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

To ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated center including the following:

- the (intermittent) unrestricted access to the center required review particularly in the context of the recent unexplained absence of a resident from the center
- the unrestricted access to the two sluice rooms was potentially hazardous to any resident with a cognitive impairment and required review
- the lack of storage racks in one sluice room potentially compromised the prevention of cross contamination practices
- the unrestricted access to the kitchen staff changing room had not been risk assessed
- the enclosed garden areas risk assessment required review to ensure that all risks were assessed including the height of the boundary wall
- there were no call bells available in the oratory room or the multi purpose room and required review to ensure compliance with regulation
- the use of wandering bracelets required review to ensure its effectiveness in the context of ten out of the 14 exit doors did not have any wandering alarm device fitted

5. Action Required:

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

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

Access to the centre has been reviewed and appropriate restrictions are in place, including the repair to the locking mechanism on the front door, which is now fully functional.

Access to the sluice rooms has been reviewed and is now restricted by use of a keypad access system.

Extra storage racks for one sluice room will be fitted which will reduce the risk of cross-contamination.

A risk assessment has been carried out on the unrestricted access to the kitchen staff changing area; this can now be accessed by staff using a keypad access system.

The enclosed garden has been risk assessed, including the height of the boundary wall. Call bells will be installed in the Oratory and Multi-purpose room to ensure that staff can be alerted if required.

The use of Wander Guard alarms will be reviewed in order to assess to ensure their effectiveness in the centre. The most frequently used entrances and exits have been fitted with Wander Guard Alarm devices. All fire exit doors have been fitted with an alarm that will activate if the door is opened. The PIC will continue to monitor these alarms and the staff response to them; regular audits will be conducted to assess, plan, implement and review the effectiveness of these devices (28/02/2018).

The PIC will ensure that all residents with a diagnosis of dementia or cognitive impairment will have a wandering assessment completed on admission and reviewed at least four monthly.

Regular absconsion drills will be conducted at the Centre to ensure staff compliance with resident monitoring and to ensure staff know how to respond to such an emergency. The absconsion drill will include a description of the missing person the scenario, immediate actions taken and response time by staff. An evaluation of the drill will include a review of compliance with the centre's policy on Residents Absconding

and learning outcomes and recommendations will be documented.
All Personal Emergency Egress Plans (PEEP) will be reviewed to ensure that records are readily available to staff in an emergency. The review of the PEEP will include whether the resident has any cognitive impairment and whether they are familiar with the sound of the fire alarm. The level of supervision the resident requires once safely evacuated will be described.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

To make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents including ensuring that the fire evacuation records record the following:

- the fire scenario being simulated during the fire drill
- the length of time taken for each practice so areas for improved evacuation times could not be identified
- any problems or deficiencies identified during the fire drill.

6. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

Proposed Timescale:

Theme:

Safe care and support

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

To make adequate arrangements for reviewing fire precautions including the following identified issues:

- the wooden floor in the smokers room required a risk assessment to ensure its suitability
- there was door wedges in fire doors in the door into the reception and the person in charges office
- the smoking risk assessment record required review to clearly demonstrate the rationale for the quantification of identified risks associated with a resident smoking
- the storage of lighters and matches in some residents bedrooms required a risk assessment to ensure the suitability/safety of this arrangement.

7. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

The PIC will ensure that residents who choose to smoke are facilitated to do so safely. A risk assessment has been conducted on the wooden floor. The floor itself is suitable for the room as long as there are appropriate care and supervision arrangements in place for residents who wish to smoke.

All door wedges have been removed and door guards will be fitted to doors that are required to be kept open, as identified by the PIC.

The risk assessments for residents who choose to smoke have been reviewed and there is a clear rationale associated with the risk and the have been categorised according to the potential severity risks have been quantified in terms of severity or probability of a hazard occurring.

This risk assessment will incorporate the circumstances in which individual residents who smoke may store matches and lighters in their rooms to ensure safety of the individual residents and to ensure that there is no risk to other residents.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

To make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

8. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

In accordance with the centre's policy on fire safety, all staff will receive Fire Safety Training as part of induction to the centre and annually thereafter; the training will include emergency procedures, evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, firefighting equipment, fire control techniques and procedures if a residents clothing accidentally catches fire.

Proposed Timescale:

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:

To store all medicinal products dispensed or supplied to a resident securely at the centre.

9. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

In accordance with legislative requirements and the centre's policy on safe storage of medication, the PIC will ensure that all medicines are stored securely and appropriately. Nursing staff will have access to Medication Management training which includes information regarding safe storage of medications. Medications not in current use will be returned to the Pharmacy in accordance with the centre's policy on disposal of unused medicinal products.

Proposed Timescale: 31/12/2017

Theme:

Safe care and support

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

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.

10. 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:

The Person in charge will ensure that all medications are administered in accordance with the directions of the prescriber, in accordance with advice provided by the resident's pharmacist and in line with Medication Management Policies of the centre and legislative requirements. Compliance with the safe administration of medications will be audited by the PIC/ADON and periodically by the Pharmacist.

Proposed Timescale: 31/12/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

To ensure that each resident may undertake personal activities in private including:

- review the arrangement for storing the handover records does not potentially compromise residents privacy in relation to their health and support care needs
- review the use of CCTV cameras in the center to ensure none potentially compromised the privacy and dignity of residents.

11. Action Required:

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

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

The Person in charge will ensure that all records are maintained in a manner that will not compromise the resident's privacy in relation to their health and support care needs and in accordance with Data Protection legislative requirements. Document shredders will be made available for staff to dispose of the handover record sheets at the end of their shift (28/02/2018).

The use of CCTV in the centre to ensure that there is no potential to compromise residents' privacy and dignity.

Proposed Timescale: 31/03/2018

Outcome 18: Suitable Staffing

Theme:

Workforce

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

To ensure that staff have access to appropriate training including training in dementia care.

12. 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:

The Person in charge will ensure that all staff have access to training appropriate to their role, to include dementia awareness and responsive behaviour training.

Proposed Timescale: 31/12/2017

