

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Ealga Lodge Nursing Home
<b>Centre ID:</b>	OSV-0005665
<b>Centre address:</b>	Main Street, Shinrone, Birr, Offaly.
<b>Telephone number:</b>	050 547 969
<b>Email address:</b>	michael@elizacare.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Underhill Investments Limited
<b>Provider Nominee:</b>	Michael Lyons
<b>Lead inspector:</b>	Sheila Doyle
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	37
<b>Number of vacancies on the date of inspection:</b>	19

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 3 day(s).

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

From:	To:
09 October 2017 11:00	09 October 2017 18:00
10 October 2017 09:00	10 October 2017 16:00
28 November 2017 08:30	28 November 2017 16:00

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

The first two days of the inspection were carried out shortly after a new provider had taken over this centre. Many of the non compliances identified were in existence prior to the new management team and person in charge taking up post. Because of this, the Chief Inspector authorised a third inspection day, six weeks later, to review progress by the new management team in response to the feedback provided from day one and two. Day one and two were announced while day three was unannounced.

As part of the inspection, the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, policies and procedures and staff and volunteer files.

The inspector also reviewed resident and relative questionnaires submitted to HIQA's Regulation Directorate prior to inspection. The feedback from the 14 completed questionnaires was mainly positive. Residents commented positively on the quality

and choice of the food. Many said that they felt safe and staff were kind to them.

Some relatives felt that breakfast was being provided too late in the day and there was not enough time to develop an appetite for lunch. The inspector saw that this had already been identified by the person in charge who had plans in place to ask residents their wishes in this regard.

Some relatives felt that staff needed to be more vigilant in their hand-washing, while another commented that sometimes there was inadequate cleaning up after meals.

Another relative suggested that it would be nice if facilities were available for relatives to make tea. One relative commented that clothing and toiletries were sometimes mixed up while another commented on improvements in the laundry service.

Overall, the inspector was satisfied with progress made to ensure that residents receive a quality service. Plans were in place to improve the service in line with the National Standards for Residential Care Settings for Older People in Ireland (2016).

The inspector found that measures were in place to protect residents from harm or suffering abuse. There were policies and procedures in place to respond to allegations, disclosures and suspicions of abuse.

The inspector found during day one and two of inspection in October 2017 that some improvements were required to ensure that the health and safety of residents, visitors and staff was promoted. The inspector found that these had been addressed on the third day of inspection.

On the first two days of inspection, the inspector found that some improvement was required to ensure that robust infection control measures were in place in relation to storage of equipment in shared en-suites. On day three the inspector saw that this had been addressed.

Improvements required to bring the risk management policy and the emergency plan in line with regulatory requirements had not been progressed on day three.

While some improvements had been made, further action was required to ensure medication management was in line with best practice guidelines.

The inspector was satisfied that each resident's wellbeing and welfare was maintained by appropriate medical and allied health care. Significant improvements to care planning documentation had been implemented within the six week period.

Several actions were required to ensure that resident's privacy and dignity was respected and that each resident was enabled to exercise choice and control over his/her life. Improvement was also required to ensure that each resident has opportunities to participate in meaningful activities. Some of these had been addressed and are discussed further in the report.

Other findings are discussed further in the report and any actions required are included in the action plan at the end.

**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 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:**

There was a written statement of purpose that described the service and facilities that are provided in the centre. It contained the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). It had recently been updated to reflect changes within the organisational structure.

**Judgment:**

Compliant

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that the quality and safety of care delivered to residents was monitored and developed on an ongoing basis. Effective management systems were in place to support and promote the delivery of safe, quality care services.

There was a clearly defined management structure that identified the lines of authority and accountability. This had recently changed with the appointment of a Director of

Operations, who is also the person in charge. She is supported in this role by the director of nursing. There was evidence of consultation with residents and their representatives.

The inspector found that many of the non-compliances found on the first two days of inspection had been addressed by day three and plans were in place to further improve the service.

An auditing schedule set out the yearly plan. Audits carried out included health and safety, medication and clinical documentation. The results of audits were shared with staff for learning and will be used to inform the annual review.

**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 designated centre was managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service. There was a clearly defined management structure which identified the lines of authority and accountability in the centre.

The person in charge worked on a full-time basis between two centres. The person in charge was supported by a director of nursing and an assistant director of nursing.

The person in charge demonstrated sufficient knowledge and implementation of the legislation requirements and was aware of her statutory responsibilities. The inspector was satisfied that the person in charge was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and had demonstrated that she was committed to improving outcomes for the residents.

**Judgment:**

Compliant

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

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

*is promoted.*

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

In October 2017, the inspector found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

There was an elder abuse policy in place that covered prevention, detection, reporting and investigation of allegations or suspicion of abuse. Residents spoken with confirmed that they felt safe in the centre. They said this was because staff were available to them at all times and access to the centre was safeguarded by staff.

The provider currently acts as pension agent for nine residents. The inspector saw that a more robust system had recently been introduced and management was now in line with national guidelines. Pocket monies were also managed for some residents. The inspector checked a sample of balances and found them to be correct. Documentation such as signed receipts and details of each transaction were maintained.

A restraint-free environment was promoted. The inspector noted that incidents where restraint was used were notified to HIOA in accordance with the regulations. The inspector noted that appropriate risk assessments had been undertaken. Usage was low and staff spoken with confirmed the various alternatives that had been tried prior to the use of bedrails. Safety checks were completed when restraint was in use.

The inspector was satisfied that residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff had received specific training. The inspector saw that appropriate risk assessments were completed. Detailed care plans were in place. Information was available on possible triggers and appropriate interventions. Staff spoken with were very familiar with appropriate interventions to use.

**Judgment:**

Compliant

***Outcome 08: Health and Safety and Risk Management***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

In October 2017 the inspector found that some improvement was required to ensure that the health and safety of residents, visitors and staff was promoted.

Procedures for fire detection and prevention were in place. Servicing records were up to date. However, although fire drills were carried out, there was limited evidence of any learning from them. For example, records did not include details of response times, when the evacuation took place or any required actions. In addition the inspector noted that no fire drill had been carried out to simulate night duty staffing levels. On day 3 in November 2017, the inspector found that this had been addressed. New recording documentation had been introduced and fire drills had been carried out to simulate both day and night time conditions.

The inspector saw that personal emergency evacuation plans (PEEPs) were developed for all residents. The inspector noted that residents were involved in this and included comments from residents such as 'I like the ski sheet'.

There was a safety statement in place. In October 2017 the inspector found that some improvement was required to ensure that robust infection control measures were in place. The inspector saw that in the shared en-suites, toothbrushes were stored together either on the single shelf or in a single tumbler. This posed a risk of infection. In addition the toiletries were stacked on the toilet cistern. Six weeks later on day three, the inspector saw that this had been addressed. New shelving had been put in each shared en-suite and each resident now had their own tumbler and adequate space to store toiletries.

In October 2017 the inspector found the risk management policy did not meet the requirements of the regulations. For example, it did not set out the measures and action in place to control some of the risks specified in the regulations. The inspector found that this was still the case on day three.

On day three the inspector found that improvements required for the emergency plan had been progressed but not completed. The emergency plan had recently been updated and contained sufficient detail to guide staff in the event of possible emergencies such as flooding. However incorrect alternative accommodation for residents was still specified in the emergency plan.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector found that some improvement was required to ensure that residents are protected by safe medication management practices.

During day one and two, the inspector reviewed a sample of medication prescriptions and administration records. It was noted that some medications were prescribed to be administered at 8am. However the administration records stated 9am. Either way the inspector saw that on the days of inspection the medication rounds did not finish until 10:30am. This meant in effect that medications were being administered two and a half hours after the prescribed time which could lead to errors and possible interactions and delayed effects. The inspector also noted that on one typed kardex somebody had written some instructions in pen beside one prescription and these instructions were incorrect. These were discussed in detail with the person in charge at the end of day two.

On day three the inspector found that this was partially addressed. Kardex had been amended. Some new kardex were in use which stated 9am as administration time. However some were still in the old system. The director of nursing said that new documentation was on order.

The timing of the morning medication round was also reviewed. Deliberate efforts were underway to ensure that staff were not disturbed when giving out the medication and regular audits were carried out to ensure that the medication round was completed with an acceptable timescale while following safe administration procedures.

Otherwise the inspector was satisfied that medication management practices were safe. Written evidence was available that three-monthly reviews were carried out. Support and advice were available for the supplying pharmacy. The pharmacy staff were also assisting in the checking of the medications provided against the prescriptions. There was a recent change to the supplying pharmacy although one resident chose to retain her existing pharmacist. The inspector was told that the pharmacist will be available to residents for advice and support.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the change of each shift. The inspector checked the balances and found them to be correct.

A secure fridge was provided for medications that required specific temperature control. The inspector noted that the temperatures were within acceptable limits at the time of inspection. There were appropriate procedures for the handling and disposal of unused and out-of-date medicines.

**Judgment:**

Substantially Compliant

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

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

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that each resident's wellbeing and welfare was maintained by appropriate medical and allied health care. However it was noted on day one and two that some improvements were required to ensure that the arrangements to meet each resident's assessed needs were consistently set out in an individual care plan.

The inspector found that residents had a comprehensive nursing assessment on admission. The assessment process involved the use of approved tools to assess each resident's risk of possible issues such as malnutrition, falls, level of cognitive impairment and their skin integrity.

Non compliances relating to care planning and documentation had been addressed by day three of the inspection. On the first days of inspection, gaps and inconsistencies were identified in the care planning documentation which could impact on the care provided to the residents. For example the inspector saw that one care plan specified two different conflicting types of diet that the resident was to be served. Neither of which reflected the dietician's recommendations. The inspector noted some gaps in the recording of blood sugar levels. In addition on reviewing wound management, the care plan in place did not specify the type of dressing to be used. These were discussed with the assistant director of nursing (ADON) who outlined plans already afoot to improve this documentation. This included introducing a different recording system which allowed progress to be reviewed and each staff member to be assigned specific interventions to be completed.

On day three the inspector saw that the new computerised system had been introduced. This introduction had required additional training for staff and more time is needed for the practice to become the norm. Overall improvement was noted.

The inspector reviewed a sample of clinical documentation including nursing and medical records. Care plans reviewed were comprehensive and person centred. They had been updated to reflect the recommendations of various health care professionals.

The inspector reviewed the management of clinical issues such as wound care and

found they were well managed and guided by robust policies.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. The inspector read where very specific information relating to residents likes and dislikes was recorded in the care plans. The inspector noted ongoing improvements in the choice and presentation of meals. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and weekly when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dietitians and speech and language therapists where appropriate. When required nutritional and fluid intake records were appropriately maintained.

There was documented evidence that residents and their families, where appropriate, were involved in the care planning process.

Documentation in respect of residents' health care was comprehensive and up-to-date. Residents had access to general practitioner (GP) services and out-of-hours medical cover was provided. A number of GPs provided services to the residents. A full range of other services was available on referral including speech and language therapy (SALT), occupational therapy, physiotherapy and dietetic services. Chiropody, dental and optical services were also provided. The inspector reviewed residents' records and found that residents had been referred to these services and results of appointments were recorded in the residents' notes.

A new system had been introduced to ensure that residents had access to chiropody services as information had been received stating that a resident was in urgent need of this service but had been absent from the centre when the chiropodist was there.

**Judgment:**  
Compliant

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

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

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

**Findings:**  
The inspector was satisfied that the complaints of each resident and their family were listened to and acted upon and there was an effective appeals procedure. During day one and two it was noted that some improvement was required to ensure that the procedure followed met the requirement of the regulations.

A log was maintained electronically and adequate details were recorded. However the complainant's level of satisfaction with the outcome was not consistently recorded. On day three, the inspector noted that this had been addressed. No new complaints had been received by the centre.

HIQA had received information and the inspector noted that this had also been received by the centre and logged in the complaints log. Investigations had been carried out and interventions put in place to minimise the risk of recurrence.

**Judgment:**

Compliant

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

During day one and two of inspection, several actions were required to ensure that resident's privacy and dignity was respected and that each resident was supported to exercise choice and control over his/her life. Improvement was also required to ensure that each resident has opportunities to participate in meaningful activities

The inspector found that some residents were wearing clothes that did not fit properly and were no longer fit for purpose. In addition the inspector saw that some residents were wearing track suit bottoms but the inspector could not determine if this was at the residents' request or for convenience. On day three, the inspector found that this had been addressed. With the involvement of residents and relatives a full wardrobe review was undertaken. The inspector saw that residents looked well dressed.

During day one and two of inspection, the inspector found that additional screening was required in some of the twin rooms to ensure that residents could undertake personal activities in private. The inspector noted on day three that currently there was only one resident in each of these rooms and the provider had arrangements in place to install additional screening as part of the current refurbishment plan. An interior decorator was expected in the centre at the time of inspection.

The inspector noted on day one and two that there were very limited opportunities for residents to go on outings. The inspector found that this was being addressed and saw

that several outings were planned for December. Residents told the inspector how much they were looking forward to this.

However the inspector noted that some days there were very limited hours available to carry out activities. For example, despite a notice on display stating that activities were to take place on the morning of day three, no staff member was allocated to this. This was discussed at the feedback meeting.

The inspector had concerns on day one and two as personal information could be overheard when staff were discussing residents on the phone. The inspector heard the conversation between a staff member and the general practitioner's office. The inspector noted that this was not the case on day three. A new fax record was set up to provide information to the GP which could then be followed up with a phone call. While no conversations were overheard during day three, this will need to be kept under review.

**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):**

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that at the time of inspection there were appropriate staff numbers and skill mix to meet the assessed needs of residents for the size and layout of the centre. Improvement was initially required to records for both staff and volunteers.

Several volunteers attended the centre and provided very valuable social activities and services, which the residents said they thoroughly enjoyed and appreciated. The inspector found on day one and two that they had been vetted appropriate to their role. However their roles and responsibilities were not set out in writing as required by the regulations. On day three, this had been addressed.

On day one and two the inspector reviewed a sample of staff files and saw that all documents required by Schedule 2 were not in place. In two of four files reviewed, there was not a satisfactory history of gaps in employment while another file did not hold two

references. On day three this had been addressed. The four staff files reviewed were complete.

Assurance was given by the person in charge that Garda Síochána (police) vetting was in place for all staff.

A comprehensive induction plan was in place. The provider and person in charge promoted professional development for staff and were committed to providing ongoing training to staff. A training matrix was maintained. Training records showed that extensive training had been undertaken and staff spoken with confirmed this.

Records read confirmed all staff had completed mandatory training in areas such as safeguarding and prevention of abuse, fire safety and moving and handling. Additional training in communication was currently organised.

**Judgment:**  
Compliant

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Sheila Doyle  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Ealga Lodge Nursing Home
<b>Centre ID:</b>	OSV-0005665
<b>Date of inspection:</b>	09/10/2017
<b>Date of response:</b>	14/12/2017

### 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 08: Health and Safety and Risk Management

#### Theme:

Safe care and support

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

The risk management policy did not meet the requirements of the regulations

#### 1. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

<sup>1</sup> 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 risk management policy is currently under review with further development to ensure it covers all aspects required under regulations and includes;  
Hazard identification and assessment of risks with the measures and action in place to control the risks identified including specific risks on abuse, the unexplained absence of any resident, accidental injury to residents, visitors or staff, aggression and violence and self harm and there are arrangements in place for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Proposed Timescale:** 20/12/2017

**Theme:**

Safe care and support

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

Incorrect alternative accommodation for residents was still specified in the emergency plan.

**2. 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:**

The emergency plan was updated on 03/11/2017 to remove and update the alternative accommodation listing. It has been reviewed to ensure that procedures for evacuating, where necessary in the event of fire have adequate arrangements to include our sister nursing home Eliza Lodge, our local community hall and two hotels locally.

**Proposed Timescale:** 14/12/2017

**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:**

Some medications were prescribed to be administered at 8am. However the administration records stated 9am.

**3. 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 medication kardex have been reprinted to include the residents start time for 09.00am as opposed to 08.00am. The new kardex are being delivered on 14th December 2017 to ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident and in accordance with any advice provided by that residents pharmacist regarding the appropriate use of the prescribed medicine. Once received these kardex will be checked and signed in by the pharmacist and the ADON to meet the prescriber's directions. Twice weekly medication audits of medication kardex continue and auditing of medication administration rounds continue as part of quality control.

**Proposed Timescale:** 15/12/2017

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

**Theme:**

Person-centred care and support

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

The inspector noted that some days there were very limited hours available to carry out activities. For example, despite a notice on display stating that activities were to take place on the morning of day three, no staff member was allocated to this.

**4. Action Required:**

Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

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

The detailed analysis and review of activity schedule is being undertaken in consultation with the residents. There is a robust and varied activity plan in place offering residents choice of visiting entertainers, outings to local shops/amenities and residents are provided with the option to take part. The activity coordinator hours have been reviewed and have increased from 22.5 hours to 42 hours per week with the activity coordinator rostered for six hours daily primarily 10.00 – 16.00. As part of increasing the activity hour's formal dedicated reminiscence therapy in the form of imagination gym is provided for residents once per week and the earlier start of 10.00 facilitates increased 1:1 activity and interaction with resident who choose not to attend group activities.

**Proposed Timescale:** 15/12/2017

**Theme:**

Person-centred care and support

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

There was inadequate screening in some twin rooms to ensure that residents could undertake personal activities in private.

**5. 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:**

These twin rooms, although currently being used as a single room have been measured for expansion of the screen and suitable screening curtains on 07/12/2017. The twin rooms identified have and will only be used for single occupancy until suitable screening has been installed.

**Proposed Timescale:** 10/01/2018