

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Nazareth House
Centre ID:	OSV-0000369
Centre address:	Church Hill, Sligo Town, Sligo.
Telephone number:	071 918 0900
Email address:	suzannenaz@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Nazareth House Management Limited
Provider Nominee:	Patrick Gaughan
Lead inspector:	Marie Matthews
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	65
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following notification of a significant incident or event. 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:
01 April 2014 10:00	01 April 2014 16:30
02 April 2014 16:00	02 April 2014 22:30

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

Outcome 01: Statement of Purpose
Outcome 03: Suitable Person in Charge
Outcome 04: Records and documentation to be kept at a designated centre
Outcome 06: Safeguarding and Safety
Outcome 07: Health and Safety and Risk Management
Outcome 08: Medication Management
Outcome 10: Reviewing and improving the quality and safety of care
Outcome 11: Health and Social Care Needs
Outcome 12: Safe and Suitable Premises
Outcome 13: Complaints procedures
Outcome 15: Food and Nutrition
Outcome 18: Suitable Staffing

Summary of findings from this inspection

This was the 6th inspection of this centre undertaken by the Authority.

The Authority received unsolicited information prior to the inspection regarding staffing levels, the provision of meaningful activities and care practices in the centre and the risks associated with same were reviewed during the inspection. The first day of this inspection commenced in the evening and carried on until night time to assess night time staffing levels.

The inspector found that residents reported a good standard of care and had good access to a range of medical and support services. They had good access to nursing, medical and allied health care and the administration of medicines was satisfactory. There were measures in place to protect residents from being harmed or suffering abuse. Residents had access an activity programme but there was still limited meaningful activity available for some residents particularly those who were not mobile or who had dementia and this was reflected in gaps in some social care plans which didn't give details of residents' interests or preferences and daily progress notes which did not comment on social activity .

The inspector found that 3 actions required from the last inspection had been satisfactorily addressed. Six of the remaining actions were only partially completed

and two related to review staffing levels in the centre and to requirement to produce a summary report of the the quality of life audits completed were not adequately addressed.

Actions that were not satisfactorily completed are discussed in more detail under the relevant outcomes and are repeated in the action plan in this report. Further action have been also been developed from other areas of non compliance observed during this inspection. These are in relation to medication management and health and social care needs.

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

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

Theme:
Leadership, Governance and Management

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

Findings:
The two actions from the last inspection were addressed and this outcome was satisfactorily met. The Statement of purpose had been reviewed and it addressed all matters listed in Schedule 1 of the Regulations. The provider had forwarded a copy of the statement of purpose to the Chief Inspector. A copy was displayed at the main entrance to the centre

Judgment:
Compliant

Outcome 03: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

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

Findings:

The centre was being managed by a suitably qualified and experienced nurse. Together with the provider, she is involved in the governance, operational management and administration activities in the centre. She works full time in the centre. During the inspection she demonstrated that she had good knowledge of the regulations and standards pertaining to residential/nursing care. She is supported in her role by the clinical nurse managers, nursing, care, administration, maintenance, kitchen and domestic staff, who report directly to her.

The person in charge had complied with mandatory training requirements and was also an appointed member of the Registration Board of Speech and Language Therapists. Additionally the PIC had completed training in Falls Prevention, Wound Management and Pressure Area Care and Infection Control since the last inspection to help ensure her professional knowledge and skills were kept up to date.

Judgment:

Compliant

Outcome 04: Records and documentation to be kept at a designated centre

The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

Theme:

Leadership, Governance and Management

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

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

Findings:

The inspector verified that the actions from the last inspection was satisfactorily addressed. Operating policies and procedures were in place as required. Records reviewed confirmed that in general documents such as staff rosters, accidents and incidents to residents and staff, nursing and medical records and operational policies and procedures were maintained however some care plans reviewed did not have social care plans provided and so were not maintained in a manner so as to ensure completeness and accuracy as required by the Regulations.

The centres adult protection policy, nutrition and the complaints policy had been revised in response to the action plan following the previous inspection and are discussed further in the relevant sections in outcomes 6 13 and 15.

Judgment:

Non Compliant - Moderate

Outcome 06: 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.

Theme:

Safe Care and Support

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

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

Findings:

The policy on Adult Protection was reviewed in response to an action plan from the previous inspection. The inspector was satisfied that it complied with the regulations. There are measures in place to safeguard residents and protect them from abuse. Staff knew what constituted abuse and what to do in the event of a suspicion or disclosure of abuse, including who to report any incidents to.

Residents stated that they felt safe in the centre and that there were adequate measures in place to protect them. The entrance to both units was protected by a key padded lock. A visitor's book was used to log all those visiting the centre.

Staff spoken with were clear on the reporting arrangements and were aware of the different forms of abuse. Training records reviewed confirmed that all staff had received training on 'Identifying and responding to elder abuse'.

Two allegations of suspected abuse had been notified to the Authority by the provider since the last inspection. The inspector reviewed documents in connection with the investigations carried out by the PIC into both allegations and was satisfied that they were appropriately investigated or being investigated and responded to in line with the centre's policy. One investigation was not concluded at the time of this inspection but the inspector is satisfied that appropriate measures had been put in place to ensure residents were safeguarded.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Safe Care and Support

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

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

Findings:

Two actions on risk management were identified on the last inspection. One action in relation to attendance of all staff at fire drills was satisfactorily addressed. An action on auditing hygiene practices had not been addressed.

On the previous inspection inspectors identified that no audit of cleaning practices had been undertaken following an outbreak of an infectious disease. An action plan was included with the previous inspection report for the provider to carry out an audit to consider if practices required review in order to prevent a further outbreak. The provider told the Authority that this would be completed in August 2013. On this inspection the inspector found that no audit had taken place and so the risks in relation to infection control were not properly assessed. This action is repeated in the action plan at the end of this report and the PIC stated that it would be immediately addressed.

There was evidence that systems were in place to ensure a safe environment was provided for residents and that controls were in place to minimize the risks identified. A safety statement for the centre was available and had been reviewed in March 2014. A monthly hazard identification checklist was completed by the Clinical Nurse Managers (CNMs) and a risk register was maintained. However, the inspector observed that there was no smoking blanket or protective apron provided in the smoking room and risks associated with residents smoking had not been adequately addressed in the risk register. The PIC said that there were only a small number of residents who smoked and they were always supervised .

There were arrangements in place for recording and investigating untoward incidents and accidents. The sample of accident/incident report forms viewed were completed and gave a good level of detail about the circumstances of and the action taken by staff following each incident. Neurological observations were recorded to determine if a head injury had been sustained and/or the level of consciousness where a resident sustained an witnessed fall. Interventions such as crash mats and mattress alarms were put in place to help prevent further falls and there was documented evidence that the number of falls had decreased. Care plans were reviewed and falls risk assessment were updated following a fall to reflect the residents changing needs. Training records reviewed showed that all staff had received manual handling training. Staff were observed to be using appropriate manual handling techniques.

Suitable fire equipment was provided throughout the centre and maintenance records showed that equipment was recently serviced. Fire exits were unobstructed and there was adequate means of escape. Staff had completed training in fire safety and additional training dates were scheduled for later in the year. The inspector verified that staff on night duty attended this training. There was evidence that fire drills were carried out regularly and all staff including night staff participated. Staff spoken with were able to describe how they would respond in the event of a fire. Instructions were displayed for the safe evacuation of residents and staff in the event of fire but the print used was small and difficult for either staff or residents with poor vision to follow.]

Judgment:

Non Compliant - Moderate

Outcome 08: Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:

Safe Care and Support

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

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

Findings:

Operational policies relating to the ordering, prescribing, storing and administration of medicines to residents were available. Photographic identification was available on each medication file to ensure the correct identity of the resident receiving the medication and reduce the risk of medication errors. Nursing staff interviewed were knowledgeable about medication and administration practices and were administering medication in accordance with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) guidelines.

Medication was transcribed by the pharmacy and signed by the General Practitioner (GP). Most prescriptions reviewed were individually signed by the GP, however, a small number of the sample reviewed had collective signatures. The maximum dose was stated for all PRN medication. The route of administration was documented on the prescription sheet of all residents. This was an action from the last inspection which was addressed.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations 1984. Nurses kept a register of controlled drugs. This was checked at the end of each shift and the inspector verified that balances were correct.

The pharmacy who supplied medication to the centre carried out audits of medication practices. The inspector was told that three monthly medication reviews were carried out by GPs; however, there was no supporting documentation available to evidence this was done.

Judgment:

Non Compliant - Moderate

Outcome 10: Reviewing and improving the quality and safety of care

The quality of care and experience of the residents are monitored and developed on an ongoing basis.

Theme:

Effective Care and Support

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

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

Findings:

This outcome was not satisfactorily met and had been the subject of an action plan developed by the Authority from findings during the last inspection of the centre. The inspector found on this inspection that there were improvements required to monitor and review aspects of the service and to inform residents of the findings. There was evidence that data was collated on some aspects of the service, for example, complaints, medication and clinical indicators such as pressure sores, restraint use and pain management. No audits of care plans had been carried out and improvements required were identified by the inspector on this inspection which was the subject of an action plan from the last inspection. This is discussed further in outcome 11.

There was poor evidence that there was any meaningful analysis of the data collated other than for statistical purposes or that any quality improvements were planned as a result of the findings. Information gathered from audits completed had not been summarised in a report and sent to the Chief Inspector as required by Regulation 35. Although a residents committee was established, the inspector did not see any evidence that information collected as a result of audits or reviews was conveyed to residents.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective Care and Support

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

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

Findings:

The actions from the last inspection were partially addressed. Improvements were noted in care planning and most care plans reviewed showed a process of review that reflected resident's needs and care requirements. However further areas were identified where improvements were needed.

The inspector reviewed a sample of residents' care plans. In general nursing and medical care needs of residents were assessed and appropriate interventions implemented. There were 65 residents accommodated in the centre on the day of this inspection. These residents had varying dependency levels and underlying medical conditions including dementia. On the day of inspection, 31 (47%) of the resident were assessed as having maximum care needs, 20 (30%) were assessed as having high care needs, 13 (20%) had been assessed as medium and one resident with low care needs.(1.5%). The PIC said approximately 30 (46%) of the residents accommodated in the centre had some level of memory loss including dementia.

Residents had access to general practitioner (GP) services including an out of hour's service. There was evidence of appropriate allied health care for example, referrals to the Dietician, Occupational Therapist Speech and Language therapist, Physiotherapists and specialists in wound care. Pre- admission assessments of residents were documented. Recognised assessment tools were used to assess care needs. These included assessments of resident's risk of falls risk, developing pressure ulcers, risk of constipation, and malnutrition.

A small number of residents had wounds. Specialist pressure relieving equipment was in use for residents identified as at risk of developing pressure ulcers and there was evidence of regular repositioning of these residents. The inspector reviewed the care plan of one resident who had a wound on his foot. The resident had been referred a specialist tissue viability nurse. Appropriate reference tools were used by staff to grade the wound. Pain assessments were documented and appropriate analgesic administered. Although there were pictures of the wound taken at regular intervals, there were no corresponding measurements documented to help staff to monitor if the wound was healing which was not in accordance with an evidence based practice approach.

Arrangements to meet residents' assessed needs were set out in individual plans of care. Most assessments informed the care plans, for example, where a resident was assessed as at risk of weight loss, a nutritional care plan was available. The inspector reviewed a sample of four care plans. There was some evidence of consultation with the resident or their next of kin in their plan of care but in two of the care plans reviewed, there was no narrative in respect of what areas of each care plan was reviewed and while signed by a relative did not include evidence of involvement by the resident.

Risk assessments were undertaken prior to bed rails or other restraints been put in place, however, the involvement of a multidisciplinary team in the decision to use a restraint was not recorded on some care plans reviewed. There was evidence of regular release of the restraint and of regular checks on the resident while the restraint was in

use.

There was a comprehensive programme of activities available which included a regular cinema club, art and craft classes, hand massage, bingo and mass was celebrated six days a week which could also viewed on the residents television in their bedrooms, Residents who were mobile told the inspector they also enjoyed meeting with friends and relatives in the centres coffee shop. There was still poor evidence that residents who had a cognitive impairment component to their diagnosis were provided with adequate meaningful activity and the inspector found that daily progress notes did not always give an indication of what activity if any the residents engaged in. Social assessments called 'a key to me' were documented in some care plans reviewed however this section had not completed in others and there were no details recorded in some of residents' interests and preferences . In some care plans reviewed by the inspector, social care assessments had not been reviewed in the past 3 months. The inspector also observed that care plans for residents with dementia did not give a clear picture of the level of cognitive function retained by the resident or the type of activities the resident might still be able to enjoy. This issue was raised on the previous inspection.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Care and Support

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

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

Findings:

The inspector reviewed the action from the last inspection which was partially addressed. A gate had been installed to secure an accessible outdoor area for residents. Some addition signage had been provided to help orientate residents with a cognitive impairment but the inspector observed that, further work is required to provide additional visual prompts to identify bedroom, bathrooms and communal rooms or where and to ensure the environment is conducive to dementia care.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The complaints procedure was displayed at the main entrance alongside a comments box. The inspector reviewed the complaints policy which had been reviewed in response to an action plan from the last inspection. The policy contained the procedures as required by the regulations including, a named person to whom complaints can be made, a nominated person who would monitor that the complaints process was followed and recorded and an independent appeals process if the complainant is not satisfied with the outcome of their complaint.

The inspector reviewed the centres complaints log. Two complaints were under investigated at the time of the inspection. These were recorded in the log together with records of all correspondence relating to the complaint. The inspector was satisfied that the PIC was following the process outlined in the complaints policy to address the issues raised and was keeping the complainant informed of the actions taken to resolve the issues raised.

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

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

Findings:

The inspector verified that the actions from the previous inspection were addressed. Food and fluid intake was monitored for residents who were deemed at risk of nutritional deficit in sufficient detail to be of therapeutic value.

Where fluid balances were been monitored the inspector saw that fluid balance charts

were totalled to assess early warning signs and identify when residents were at risk of dehydration and/or nutritional deficit.

Judgment:

Compliant

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.

Theme:

Workforce

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

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

Findings:

The action required from the previous inspection was not adequately addressed. The inspector identified issues with staffing levels and the deployment of staff again on this inspection which required immediate review. The inspector spoke to both the provider and the PIC following the inspection and they gave a commitment to address this deficit immediately.

There were 65 residents in the centre on the day of inspection. The inspector reviewed staff rosters and found that the normal allocation of staff on duty during the day was two nurses and five care assistants in each unit. On the previous inspection there were three nurses and five care assistants in each unit looking after 59 residents. Staffing levels up to 10.30pm consisted of one nurse and two care assistants in each unit. After 10.30 one nurse and one care assistant supervised residents in each unit until 8am.

In response to the action plan from the previous inspection, the provider stated that he would thoroughly review staffing levels and adjust accordingly. The evidence from this inspection was that staffing levels had been reduced since the last inspection despite an increase in the number of residents. Clinical Nurse Managers on duty did not have any protected time for governance work. No audits of care planning had taken place since the last inspection. The inspector observed that three complaints were recorded in the centres complaint log linked to staffing levels and the risks associated with this.

Night staff on duty told the inspector that once medication administration is completed, they usually work together on one floor. This meant that the residents on the other floor in each unit are unsupervised. Residents spoken with said that there was enough staff on duty most times, but felt that at night time there were not always enough staff to respond to their needs in a timely fashion. The inspector observed the ground floor of

the Holy Family unit between 9.30pm and 10pm. Three residents were sitting in the sitting room unsupervised. Two other residents were heard calling for assistance from their bedrooms. The inspector observed that there were no staff in the vicinity to attend these residents at the time as both staff on duty were upstairs. In response to the action plan from the previous report the provider said he planned to purchase a computerised call bell response monitoring system to allow management to identify and properly assess any failure or delay in responding to call bells. This had not yet been obtained. The PIC said that the staff carried a mobile alert system to help them identify and respond to call bells at night time, however, the inspector observed that neither of the residents who were calling for assistance had used the call bell provided.

The inspector reviewed a sample of three staff files and all documents required under Schedule 2 of the Regulations including up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann and evidence that staff were appropriately vetted was contained in the personnel files reviewed. A range of mandatory and professional development training had been completed and further training was ongoing amongst all staff.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Marie Matthews
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:	Nazareth House
Centre ID:	OSV-0000369
Date of inspection:	01/04/2014 and 02/04/2014
Date of response:	04/06/2014

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 04: Records and documentation to be kept at a designated centre

Theme:

Leadership, Governance and Management

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

some care plans reviewed did not have social care plans provided and so were not maintained in a manner so as to ensure completeness and accuracy as required by the Regulations.

Action Required:

Under Regulation 22 (1) (i) you are required to: Maintain the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) in a

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

manner so to ensure completeness, accuracy and ease of retrieval.

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

A number of workshops are planned with staff to ensure that all care plans are updated no less frequently than every three months. The care plans will accurately reflect the residents actual needs and care requirements.

Proposed Timescale: 01/08/2014

Outcome 07: 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 provider had not addressed an action from the previous inspection requiring the risks in relation to infection control be properly assessed as an audit of cleaning practices had not been carried out;

There was no smoking blanket or protective apron provided in the smoking room and risks associated with residents smoking had not been adequately addressed in the risk register.

Action Required:

Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

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

Currently we do not have any resident in the service who smoke. However a smoking risk assessment has been included in the risk register. Also a smoking apron/blanket is on order to ensure that a safe environment can be maintained for any resident who smokes.

Proposed Timescale: 15/06/2014

Theme:

Safe Care and Support

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

Instructions were displayed for the safe evacuation of residents and staff in the event of fire but the print used was small and difficult for either staff or residents with poor vision to follow.

Action Required:

Under Regulation 32 (3) you are required to: Display the procedures to be followed in

the event of fire in a prominent place in the designated centre.

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

Instructions will be displayed for the safe evacuation of residents and staff in the event of fire in larger print to ensure that it is clear for all staff and residents.

Proposed Timescale: 15/06/2014

Outcome 08: Medication Management

Theme:

Safe Care and Support

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

Some prescription sheets reviewed were not individually signed by the GP and collective signatures were used

There was a system in place for all medication to be reviewed by the prescribing doctor every three months or more frequently should a change in residents' health occur but there was no supporting documentation available to evidence this was done.

Action Required:

Under Regulation 33 (1) you are required to: Put in place appropriate and suitable practices and written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents and ensure that staff are familiar with such policies and procedures.

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

Each of the GPs who support residents in the service will be written to and informed again that each drug must be signed for. The prescriptions will be audited to ensure on going compliance. Both the pharmacist and the GPs are regularly reviewing medications, however it is not being consistently documented in an agreed location on the residents GP file. A location will be agreed and the practice will be subjected to audit.

Proposed Timescale: 01/08/2014

Outcome 10: Reviewing and improving the quality and safety of care

Theme:

Effective Care and Support

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

There was poor evidence that there was any meaningful analysis of data collated other than statistical or that quality improvements were planned as a result of the findings.

Information gathered from audits completed had not been summarised in a report and

sent to the Chief Inspector as required by Regulation 35.

A residents committee was established but there was no evidence that information collected as a result of audits or reviews was conveyed to residents.

Action Required:

Under Regulation 35 (3) you are required to: Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

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

All of the data collated from audits and reviews will be collated quarterly and presented to residents in an understandable easy read format. This will then be presented to residents at consumer group meetings. Residents can contribute to any quality improvement targets that can be planned for the next quarter.

In addition this quarterly information update of audits and reviews will be summarised in a report and sent to the Chief Inspector as required by Regulation 35.

Proposed Timescale: 30/06/2014

Outcome 11: Health and Social Care Needs

Theme:

Effective Care and Support

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

Residents who had a cognitive impairment component to their diagnosis were not provided with opportunities to participate in meaningful activities.

Daily progress notes did not give any indication of any meaningful activity engaged in by residents. In some care plans reviewed social assessments had not been reviewed in the past 3 months, did not give a clear picture of the residents interests or of the level of cognitive function retained by each resident or the type of activities the resident might still be able to enjoy

Action Required:

Under Regulation 6 (3) (d) you are required to: Provide opportunities for each resident to participate in activities appropriate to his/her interests and capacities.

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

A number of workshops are planned with staff to ensure that all care plans are updated no less frequently than every three months. The care plans will accurately reflect the residents actual needs, care and social requirements.

The residents programme is supported by the pastoral care staff, VEC schemes, volunteers and the Leader, Tus programme.

- Six days a week the unit celebrates mass in the Oratory. Residents can watch this

daily mass from their rooms on TV or attend on a daily basis. All residents have TVs in their bedrooms.

- Crafts sessions were available on a Monday
- Summerhill College students visit on a Monday as part of an intergenerational programme for transition year students.
- On Tuesdays the residents have Art classes the residents have just launched their Art and Craft exhibition which is on display as part of the Bealtaine Festival in the coffee shop.
- On Wednesday afternoon the residents participate and enjoy Bingo.
- The Unit has two hairdressers on site 3-4 times per week. A beautician is available by appointment.
- On Thursday there is a sing along, Poetry and hand massage.
- On Friday and Sunday afternoons Irish Therapy dogs and their owners visit the unit.
- In addition the unit has an Art Gallery and a variety of exhibitions are displayed here.
- The unit has a library with an extensive range of books, audio books, audio weekly newspaper, and large print books for those with visual impairment.
- Outside the grounds are well maintained and are wheelchair accessible.
- The unit has a cinema club who get together bi monthly. The club nominate a movie to watch, usually it is a classic for example "Gone with the Wind". The units training room can be transformed into a cinema with a large screen and surround sound.
- In addition on the first Wednesday of every month a large number of volunteer traditional dancers and musicians visit the service and play for the residents from 7.30pm until 9pm.
- The Butterfly Company have visited the service four times since the last inspection and put on a most enjoyable variety show for the residents.
- Currently the unit has a volunteer through the Leader programme she engages with the residents, helps take residents to mass, out on the grounds for walks or use the library or view the art exhibition.

Proposed Timescale: 01/08/2014

Theme:

Effective Care and Support

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

There were no measurements documented to assist staff to monitor if the wound was healing which was not in accordance with evidence based practice.

The involvement of a multidisciplinary team in the decision to use a restraint was not recorded on one care plan reviewed

Action Required:

Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.

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

Since May 2014 the company who manufacture the Visi track and the wound depth

indicators have stopped manufacturing these products. The CNS in Tissue Viability and the HSE purchasing department are working to try and source alternative products.

All restraint use will include the involvement of the multidisciplinary team in the decision to use a restraint.

Proposed Timescale: 04/06/2014

Theme:

Effective Care and Support

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

in two of the care plans reviewed there was no narrative in respect of what areas of each care plan was reviewed and while signed by a relative did not include evidence of involvement by the resident.

social assessments had not been reviewed in the past 3 months and did not give a clear picture of the residents interests or of the level of cognitive function retained by each resident or the type of activities the resident might still be able to enjoy.

Action Required:

Under Regulation 8 (2) (c) you are required to: Revise each residents care plan, after consultation with him/her.

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

A number of workshops are planned with staff to ensure that all care plans are updated no less frequently than every three months. The care plans will accurately reflect the residents actual needs, care and social requirements.

Proposed Timescale: 01/08/2014

Outcome 12: Safe and Suitable Premises

Theme:

Effective Care and Support

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

Work is required to provide visual prompts for residents with dementia to where their bedroom is, or where the nearest toilet or sitting room is located and to ensure the environment is conducive to dementia care.

Action Required:

Under Regulation 19 (3) (a) you are required to: Ensure the physical design and layout of the premises meets the needs of each resident, having regard to the number and needs of the residents.

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

The Unit will provide and erect more dementia friendly signs throughout all areas of the unit to ensure that visual prompts are available for all residents.

Proposed Timescale: 01/08/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The number / deployment of staff on duty was not sufficient to meet the needs of all residents given the size and layout of the centre.

There were no staff supervising some communal areas during the inspection

No meaningful review of staffing levels had been conducted to ensure staffing levels and the deployment of staff was adequate to meet the assessed needs of all residents.

Action Required:

Under Regulation 16 (1) you are required to: Ensure that the numbers and skill mix of staff are appropriate to the assessed needs of residents, and the size and layout of the designated centre.

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

The DOS and the CEO are currently carrying out a complete review of the staffing levels. The main focus is the numbers of staff on duty at the different times of the day, rosters, the activity levels of the 24 hours of the day, absenteeism, resident dependency levels, complaints, observation, hazards, near miss, incidents, completing a comparative analysis of staffing levels in other nursing homes and an examination of best practice. Recommendations from this review will be actioned to ensure that there are enough staff on duty to meet the needs of all residents.

The unit has a computerised call bell response monitoring system on order, this will allow management to identify and properly assess any failure or delay in responding to call bells.

Proposed Timescale: 30/06/2014

Theme:

Workforce

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

There was no documentary evidence available to verify that the PIC had attended any professional training to maintain her clinical skills.

Action Required:

Under Regulation 17 (1) you are required to: Provide staff members with access to education and training to enable them to provide care in accordance with contemporary evidence based practice.

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

The PIC has no recollection of any reference to these statements. She was not asked for this information during the inspection. Please find attached a copy of the CPD that she has been involved in for the past year. In addition please note that that she is a member of the Registration for Speech and Language Therapists through CORU, by the appointment of the Minister for Health and had been informed at a previous inspection that this was relevant CPD for her role as PIC. This letter was on file and was examined by the inspector. Please find attached to this document evidence regarding the CPD that the PIC is engaged in since the last inspection.

Proposed Timescale: 04/06/2014