

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Aras Chois Fharráige
<b>Centre ID:</b>	OSV-0000382
<b>Centre address:</b>	Pairc, An Spidéal, Galway.
<b>Telephone number:</b>	091 553 194
<b>Email address:</b>	araschoisfharráige@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Aidan & Henrietta McGrath Partnership
<b>Provider Nominee:</b>	Aidan McGrath
<b>Lead inspector:</b>	Jackie Warren
<b>Support inspector(s):</b>	Linda Moore
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	42
<b>Number of vacancies on the date of inspection:</b>	0

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. 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:
04 September 2014 10:00	04 September 2014 18:30
05 September 2014 07:30	05 September 2014 19:30

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

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

**Summary of findings from this inspection**

This monitoring inspection was unannounced and took place over two days. The inspectors met with residents, relatives and staff members as part of the inspection. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspectors were very concerned that the provider was not ensuring that an adequate standard of evidence based care was provided to residents. They were further concerned that the provider had not completed actions required following most recent inspections within the agreed time frames and previously agreed improvements which had been commenced had not been sustained.

An Immediate Action Plan containing six actions was issued during the inspection.

There were significant issues identified during the inspection relating to healthcare, the management of restraint, management of nutritional issues and documentation of care planning interventions. The provider was requested to take immediate action to address these health care risks.

The management of environmental risk, fire safety awareness and medication management were also identified as risks that required immediate action.

The inspectors found that staffing levels and skill mix and staff supervision were not adequate and this impacted on the delivery of appropriate and safe care to residents.

Issues relating to laundry services, privacy in shared bedrooms, provision of suitable recreational opportunities for all residents, staff recruitment, infection control and policies and procedures were also identified as non-compliant during this inspection.

Evidence of good practice was found in other areas of the service. The building was warm, clean, comfortable and well maintained. There was a variety of communal spaces available to residents. Residents had good access to general practitioners and health professionals.

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

***Outcome 01: Statement of Purpose***

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

**Theme:**

Governance, Leadership and Management

**Findings:**

The statement of purpose was under review by the provider.

The provider had previously developed a suitable statement of purpose. He advised the inspectors that the statement was currently being revised to reflect the requirements of the new Regulations and a copy would be forwarded to the Authority on completion.

**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

**Findings:**

Governance and management systems in place were not fully effective in ensuring that the service provided was safe, appropriate, consistent and adequately monitored. This resulted in poor outcomes for residents in healthcare, risk of falls, medication administration, nutrition, supervision by staff. The policies and procedures did not sufficiently guide staff and risk management was poor. These non-compliances are further discussed in outcomes 5, 8, 9, 11, 15 and 18 of this report.

There was an improvement in the hours worked by the person in charge since the last inspection as she now worked full time in the role of person in charge of the centre. However, deficits were identified in the person in charge's supervision of the assessment and management of health care needs and the supervision and allocation of staff, which are discussed in outcomes 11 and 18 of this report.

There were limited systems in place to review and monitor the quality and safety of care and the quality of life of residents for the purpose of learning and improving the service. For example, falls were not being suitably audited to identify trends and introduce appropriate interventions to control this risk.

**Judgment:**  
Non Compliant - Major

***Outcome 03: Information for residents***

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

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The provider had previously devised a suitable contract of care which had been agreed with all residents. The contract was being revised by the provider at the time of inspection and he stated that a copy of the final document would be provided to the Authority in due course.

The residents guide was not reviewed at this inspection as the provider stated that it had not been revised since last reviewed on inspection.

**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

**Findings:**  
There was a person in charge in the centre who had the required experience in nursing older persons. The person in charge worked full time and was rostered for duty most weekdays. She knew all the residents and their relatives. There were issues identified around the clinical governance by the person in charge and this is discussed in Outcome 2.

**Judgment:**  
Compliant

***Outcome 05: Documentation to be kept at a designated centre***

*The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

**Theme:**  
Governance, Leadership and Management

**Findings:**

The inspectors reviewed a range of documentation in the centre, including operational policies and procedures and records relating to staff recruitment, medication management and health care, and found that improvement was required. Most of the policies required by the Regulations were present, however, policies required improvement and there was no policy for staff training and development.

A sample of the policies reviewed contained insufficient information to guide practice and some were not centre specific, including:

- the personal property policy did not provide guidance on how safekeeping of residents' valuables would be managed if required
- the end of life policy did include direction on undertaking end of life assessments
- the nutrition policy did not sufficiently guide staff on completing nutritional assessments and initiating nutritional plans of care.

There was a lack of consistent version control of the policies in use resulting in different versions of policies being made available to staff at different times. For example, the complaints policy did not identify the person responsible for ensuring that records are suitably maintained and that all complaints are appropriately responded to. A version of this policy viewed at a previous inspection provided more comprehensive guidance to staff.

The emergency plan in use at this inspection did not provide sufficient guidance for managing emergencies other than fire, emergency accommodation and emergency transport details.

The provider had not ensured that all staff were suitably recruited. The documentation in a sample of staff files was viewed by an inspector and was found to be inadequate. The files of some staff recruited since the last inspection did not include much of the required information such as two written references, a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012,

documented evidence of relevant training and a recent photograph. Up to date registration details were retained for all nursing staff.

Suitable records of residents' plans of care, medication errors, health care assessments and use of restraint (bed rails) were not being maintained as required by schedule 3 of the Regulations.

An inspector viewed the fire safety register and was satisfied that records of fire drills, fire training and servicing of fire safety equipment were maintained.

A record of visitors entering and leaving the building was maintained by means of a sign-in sheet in the reception area.

The insurance policy and directory of residents were not viewed on this inspection.

**Judgment:**

Non Compliant - Moderate

***Outcome 06: Absence of the Person in charge***

*The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**

Governance, Leadership and Management

**Findings:**

The provider was aware of the requirement to make notification to the Authority for the prolonged or unexpected absence of the person in charge. To date this had not been necessary.

**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

**Findings:**

The inspectors reviewed the processes in place for the management of elder abuse and found that improvement was required in relation to the abuse policy, knowledge and understanding of elder abuse and management of behaviours that are challenging.

There was an elder abuse policy, which detailed the process for the investigation of an allegation of abuse, but did not provide guidance in all aspects of detecting, reporting and investigating suspicions of abuse. For example, the policy did not explain different types of abuse, or provide adequate guidance on responding to an allegation in terms of the care and support of the suspected abused person and the required notifications to be submitted to the Authority.

The person in charge stated that all staff received training in the detection, reporting and responding to allegations of abuse as part of their induction and staff confirmed that this was the case. However, the person in charge was not sufficiently clear on how an allegation or suspicion of abuse would be investigated and some staff were not sure what constituted abuse.

The restraint policy was brief and did not provide sufficient information to guide staff on the assessment and use of restraining devices such as bed rails, lap belts and tilted chairs. The inspectors were not satisfied that the reasons for the use of bed rails or tilted chairs had been assessed. In addition, appropriate risk assessments had not been undertaken for residents who used bed rails while in bed and there was no documented evidence that alternatives had been considered before the introduction of this restraint measure. Care plans had not been developed for the care and supervision of residents who used bed rails. There was no evidence that staff had received training in management and assessment of restraint. A restraint register had not been developed as required by the Regulations.

The inspectors were not satisfied that there were adequate processes to manage behaviours that were challenging to protect all residents as required. While there was an informative policy to guide this area of care, behavioural charts had not been initiated or care plans developed in line with the guidance of the policy. Staff had not received up to date training in management of behaviours that challenge.

**Judgment:**

Non Compliant - Major

***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):**

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

**Findings:**

The provider and person in charge had failed to manage a number of serious risks and the provider was requested to take immediate action to address these. Following the inspection he identified control measures that he was introducing.

The provider had put measures in place to protect the safety of residents, staff and visitors to the centre. However, there was insufficient hazard identification and controls put in place in relation to manual handling practices, smoking, access to dangerous substances and absconsion.

Risks in relation to falls management and choking were also identified and these are discussed in outcomes 11 and 15 of this report.

Many aspects of fire safety control were well managed, however, staff understanding of evacuation procedures required improvement. In addition, the inspectors found that improvements to the risk management policy, as identified in previous inspection reports had not been completed.

The inspectors viewed the risk management policy and risk register. While the risk management policy and register identified a range of hazards specific to the centre, it did not include all the specific risks as required by the Regulations. The inspectors found that insufficient hazard identification had not been carried out in relation to absconsion, smoking, manual handling and access to dangerous materials and appropriate control measures put in place. Deficits in identification of risk had been highlighted during previous inspections and had been included as a required action. Following the inspection of the centre in December 2013, the provider had stated in his response to the required action that he was in the process of updating the risk management policy to reflect the legal requirements within an agreed time frame. The inspectors found that this had not been completed.

During previous inspections the doors into areas where hazardous substances were stored such as the laundry, sluice and clinical room were securely locked. On this inspection, these doors continued to be well secured, but some hazardous materials such as cleaning materials and matches were stored in readily accessible areas where they could present a risk to some residents.

There was a centrally located smoking room available for use by residents who wished to smoke. This area had not been suitably risk assessed.

The person in charge was a manual handling instructor and she provided manual handling training to staff on induction and at intervals thereafter. Staff confirmed that they had receive training in moving and handling from the person in charge. However, as the person in charge did not maintain a training matrix it was difficult to establish when this training had occurred and when it was due to be repeated for each staff member. Records of manual handling training were retained on individual staff files and records on one file indicated that a staff member had not received this legally required training within the past three years. The inspectors noted some unsafe manual handling practices in use. For example, brakes were not applied to some wheelchairs during

transfers, the use of a hoist had been discontinued for a resident without an assessment for this change being undertaken, unsafe manual handling practices were described to the inspectors and staff were observed working and moving residents, including making transfers, while wearing inappropriate and unsafe footwear.

While arrangements were in place for staff to receive regular fire training, some staff were not sufficiently knowledgeable of crucial evacuation processes. Staff explained that annual fire training was carried out by an external company although it was difficult to establish if all staff had received this training as the person in charge did not maintain a training matrix. In addition, two staff who had received fire warden training had delivered fire safety training to new staff on induction and also delivered additional fire training and organised fire drills. Staff had been examined in fire alarm response but not in their understanding of evacuation techniques. Some staff who the inspector spoke with knew what to do in the event of a fire. Others, including one who sometimes held responsibility during night shifts, were not sure of how residents would be evacuated in the event of an emergency.

Fire safety records showed that all fire equipment, including extinguishers, alarms and emergency lighting, had been regularly serviced. Regular internal fire safety checks were being undertaken, including checks of fire alarm system and automatic door releases, escape routes and fire exits.

All fire exits were clear and unobstructed. Fire evacuation orders were displayed in different parts of the building. There was an emergency response team one of who was always available out of hours.

The inspectors were not satisfied that there were adequate systems in place to control the risk of spread of infection in the centre. There was a draft infection control policy under development, which did not provide sufficient guidance on infection control measures such as laundry practices and cleaning of bed pans and commodes. Some residents used bed pans and commodes. Staff told inspectors that they had received no guidance or training on sanitising these items and the cleaning methods that staff described for cleaning this equipment that staff were not in line with infection control guidelines and presented a risk of cross infection.

Some care staff were involved in both resident care, such as personal care and assisting at mealtimes, and housekeeping duties, such as cleaning and laundry, in the same shift. There was no protocol around how this would be managed to prevent the risk of cross-infection.

**Judgment:**  
Non Compliant - Major

### ***Outcome 09: Medication Management***

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

#### **Theme:**

Safe care and support

#### **Findings:**

The provider and person in charge had not taken measures to ensure that residents were protected by safe medication management policies and practices. Medication was not managed and administered safely. The inspectors identified some medication administration practices which were unsafe. Areas of medication management that required improvement included, the medication policy, storage of medication, management of medication errors, management of PRN (as required) medication and telephone prescriptions. An immediate action was issued during the inspection.

Medication management, including the medication management policy, was identified as an area for improvement during previous inspections.

The medication policy was generic and did not provide sufficient guidance to staff on medication management processes, such as, crushing, administration of PRN medication, medication errors and telephone prescriptions. The provider had previously stated in his response to action required that this would be addressed by the end of December 2013, however, this has not been completed. Operational policies are further discussed in Outcome 5.

A nurse on duty outlined the procedures and practices on medication management and administration and an inspector reviewed the prescribing and administration charts. The inspector found some poor practices in medication management. For example:

- a PRN medication had been administered in excess of the maximum dosage prescribed by the general practitioner (GP)
- nurses administered some medicinal products which had not been suitably prescribed
- a supply of crucial PRN medication for a resident was not available as the product in stock was out of date
- out of date stock was inappropriately stored, and
- a medication prescribed for night administration was being administered in the mornings.

Improvements were required in the storage of medication. There was a medication fridge, however, the inspectors found that eye drops were inappropriately stored in a food fridge that was in a communal area and accessible to residents and visitors. In addition, there was no process for dating products with a specified shelf life to ensure that the date of minimum durability was not exceeded after opening.

In addition, there was no system for auditing medication practices and the competency of staff. There was no evidence that staff had received training in medication management.

Medication errors were not being suitably recorded and reviewed for learning and improvement of service. The person in charge said that there had never been a medication error, although an inspector identified several medication errors in the course of the inspection.

Each resident's medications were stored in the medication trolley which was safely secured when not in use. There were colour photographs of residents on the administration charts, which the nurse could check to verify identification. The medications listed on administration sheets were individually signed by the GPs. The nurses recorded and signed to confirm each medication administered and an up-to-date nurses' signature sheet was available. Nurses transcribed medication from the GPs' original prescriptions and these entries were suitably witnessed and signed.

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. An inspector checked the balances of some and found them to be correct.

**Judgment:**  
Non Compliant - Major

***Outcome 10: Notification of Incidents***

*A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.*

**Theme:**  
Safe care and support

**Findings:**  
There was a system for recording and notification of incidents and accidents. Separate incident and accident record books were retained in the centre in which details of accidents and incidents were recorded. The person in charge and the provider were aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. Events recorded since the last inspection had been notified to the Chief Inspector.

**Judgment:**  
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):**

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

**Findings:**

The inspectors were not satisfied that each resident's wellbeing and welfare was maintained by a high standard of nursing care and found that there were significant concerns in the management of nutrition, wounds, falls and epilepsy. An immediate action was issued during the inspection.

Comprehensive assessments and a range of additional risk assessments had been carried out for the majority of residents and staff had developed care plans based on the risks and care needs identified. However, a sample of care plans reviewed lacked sufficient detail to guide staff in the delivery of care.

Further improvement was required to the management of residents' nutritional needs. While residents were being weighed and their weights were recorded every month, some nutritional care plans had not been updated to reflect current requirements and interventions, such as, modified consistency diets, recommendations of the speech and language therapist and changes to nutritional plans due to significant weight change.

The nutritional policy was not sufficiently informative to direct staff in all aspects of nutritional care. For example, the policy did not include adequate guidance on nutritional assessment and actions to be implemented in the event of nutritional risks being identified. Policies are further discussed in outcome 5 of this report. This had been brought to the attention of the provider at a previous inspection and he had identified a time frame within which this would be addressed, although this had not been completed.

While the person in charge and staff explained that no residents had developed wounds or pressure ulcers in the centre there had been a small number of wounds that had occurred elsewhere and were at an advanced stage of healing. The inspectors reviewed the management of wound care and found that some improvement was required. Interventions in place to promote healing and wound progress were not well documented and were not sufficiently detailed to guide continuity of care.

Some residents were identified as being at high risk of falls. The inspectors did not find evidence that adequate post-fall observations had consistently been undertaken. For example, one resident who had sustained a serious injury from a fall did not have neuro-observations undertaken in the time following the fall. Staff who spoke with an inspector were not sufficiently clear on the best practice for monitoring neurological function after a possible head injury as a result of a fall.

The inspectors viewed the end of life assessments in a sample of residents' files. There was evidence that residents were regularly reviewed by their GPs and with increased

frequency as they approached end of life. However, the inspector found that suitable assessment of end of life wishes had not been undertaken for some residents and that specific care plans had not been developed to guide end of life care.

Staff were not knowledgeable on the management of epileptic seizures. Staff had received no training in this area of care and there was no policy on care of residents with epilepsy. Furthermore, there was insufficient care plan guidance in resident care plans. All relevant resident information from a former designated centre/hospital had not been captured to inform care planning appropriate to resident needs.

An inspector also noted insufficient follow-through on a health care issue. There was no evidence that blood pressure monitoring was undertaken for a resident who had been queried as having postural hypertension.

Residents had access to GP and other health care services and a physiotherapist came to the centre every week. Records of medical visits and health care consultations were written up in the residents' notes.

**Judgment:**  
Non Compliant - Major

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

*The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

**Theme:**  
Effective care and support

**Findings:**

The building was well furnished and was clean, bright and comfortable with ample communal space for residents. All bedrooms had spacious, accessible ensuite facilities and there were sufficient additional bathrooms available to residents.

Both the grounds and the enclosed garden were well maintained and residents were using the outdoor spaces during the inspection.

A high standard of hygiene was being maintained in the building. There were hand-washing stations in the corridors and ample supplies of hand sanitising gels for staff, residents and visitors to use.

There was a call bell system in place and regular assessments were undertaken to review response times and to establish the best positioning of call bells for residents' needs.

Maintenance and servicing records viewed by an inspector confirmed that equipment and appliances were in good working order and had been serviced regularly by external contractors. There was a full time maintenance person employed in the centre, who was also on call out of hours. He was responsible for ongoing maintenance and upkeep in the centre.

**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

**Findings:**

Practice in relation to complaints management required some improvement.

The procedure for complaints was displayed for residents and it clearly identified the complaints officer. Complainants who were not satisfied with the initial response to their complaint were directed to an independent appeals process.

There was a complaints policy which required some revision and is referred to in outcome 5 of this report. The provider had also identified another person who held a monitoring role to ensure that complaints were responded to.

There were two complaints registers in which details of complaints were recorded. Details of the investigation into the complaint, the outcome and complainant's level of satisfaction with the outcome was not recorded in one of the registers in accordance with the requirements of the Regulations.

**Judgment:**  
Non Compliant - Minor

***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

**Findings:**

The nutritional needs of residents were not consistently well met. Residents' nutritional needs had been assessed, referrals to health care professionals had been made, recommendations of dieticians and speech and language therapists had been recorded and the person in charge had developed an information sheet highlighting all residents' nutritional needs and status. However improvement was required and an immediate action plan was issued during the inspection.

Having reviewed care plans, observed mealtimes and discussed nutritional requirements with staff, the inspectors found that some residents' dietary requirements were not being provided in line with the requirements of dietetic and speech and language therapists. The recommendations of health care professionals specified the consistency of meals required for specific residents and the positioning of some residents at mealtimes, to control choking risks. Meals were not provided to some residents in line with these guidelines and some residents were not appropriately seated at mealtimes which placed them at risk. For example, the speech and language therapist had recommended a soft textured diet and no bread for some residents and these residents were given sandwiches for their evening meal.

The inspectors observed lunch and evening meal being served. Lunch was the main meal of the day and was served either in the dining room, communal rooms or in the bedrooms. Residents were asked their preferred choices in advance and staff supplied this information to the chef. Residents confirmed this to be the case. The chef prepared and plated the required food which was distributed to residents by the care staff. Many of the residents in the centre were of maximum dependency and required assistance at mealtimes. Staff were observed to assist residents in a respectful manner during the inspection.

There was a well equipped and hygienic kitchen, which was connected to the dining room by a serving hatch. An inspector met with the chef and viewed the menu plan which offered two daily main meal choices although alternatives would be arranged for residents who wanted something else to eat. The evening meal options offered a choice of sandwiches, soup, eggs, baked products and cooked breakfast cereals such as porridge. The chef prepared homemade bread or confectionery daily and made fresh vegetable soup several times each week. Residents confirmed that this was the case and were complimentary of the food. Residents and staff also stated that snacks were available as required.

The provision of suitable alternatives to residents with special dietary needs required improvement. The chef explained that, for dessert tinned fruit and sugar free jelly and yogurt was provided to residents with diabetes. No other suitable alternatives were made in the kitchen or bought in for these residents and therefore they did not have the same choices of desserts, confectionery and baked products as other residents.

The inspectors reviewed a sample of records and found that each resident had nutritional assessment, using a recognised assessment tool, carried out on admission and at three-monthly intervals thereafter or more frequently if required. Residents' weights were routinely monitored and recorded. Improvement was required to the development of nutritional care interventions and this is discussed in outcome 11 of this

report.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

Outcome 16 was not fully inspected at this inspection, but the the privacy of residents in shared rooms was reviewed and found to be unsatisfactory. The privacy screening arrangements in shared bedrooms were inadequate. Most residents had single rooms but some twin rooms accommodated two residents. The privacy screening in these rooms could not be fully extended around beds to provide maximum privacy to residents as required. The provider had indicated in December 2013 that this work was in progress and there was a plan for its completion. This work had not been completed as planned.

The inspectors were not satisfied that all residents had the opportunity to participate in recreational activities suited to their abilities. While there was a recreational plan in place, this was delivered by one staff member who also fulfilled another role in the centre. The inspectors observed that, apart from the times when organised activities were in progress, there was no social interaction or engagement with many residents. There was no plan to deliver appropriate recreational activities or stimulation to residents with dementia and cognitive impairment. Some of these residents were seen to sit in their chairs for very long periods with little or no interaction with staff. Some staff had training in therapeutic technique for people with dementia but sessions of these techniques were not planned for residents on a regular basis.

The provider had taken measures to give residents and their families opportunities to express their views on the running of the centre. There was a residents' and relatives' forum that met bi-monthly. An inspector read the minutes of a recent meeting, during which staffing levels and the provision of suitable activity for all residents had been raised as an issue.

**Judgment:**  
Non Compliant - Major

**Outcome 17: Residents' clothing and personal property and possessions**  
*Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

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

**Findings:**  
Outcome 17 was not fully inspected on this inspection. The management of laundry was reviewed and required improvement.

Residents' laundry was carried out in the centre and improvement was required to the identification of items of clothing to ensure that residents' own clothes were returned to them. An inspector viewed this system and found that while clothing was labelled, the labelling was not clear and it was difficult to decipher. Staff members agreed that this was the case. During the inspection inspectors had received feedback that sometimes clothing went missing or was returned to the wrong residents.

Residents had adequate space and storage facilities in their rooms to store and retain control of their own possessions.

**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

**Findings:**  
The staffing level and skill mix at certain times of day or night was not adequate to meet the needs of residents. The inspectors reviewed staffing levels and skill mix and were concerned that staffing levels had not been sufficiently maintained to consistently meet the assessed needs of all residents. The inspectors noted that key factors such as

residents' numbers, dependency levels and the size and layout of the centre had not been adequately used to inform and review staffing skill mix. The inspectors found that one nurse and two care assistants were rostered to meet the needs of all residents at night regardless of the number of residents, their changing needs and dependencies and the layout of the centre.

From a review of staff rosters the inspectors found that there was one or two nurses on duty in the afternoons and evenings and always one nurse on duty at night until 8am. On these shifts this nurse was responsible for administering medications to a significant number of residents as well as supervising the delivery of care and attending to residents that required nursing intervention. As a result, the inspector was concerned that this could impact on the provision of care to residents and supervision of staff.

Staff members are not supervised appropriate to their roles. There were no clear lines of responsibility particularly in the afternoons, evenings and at night time. The inspectors observed practice and discussed this with staff. At the morning handover meeting care staff were each allocated a named group of residents who they would care for in the mornings. Later in the day, there was no responsibility assigned to staff for the care delivered to individual residents. The person in charge, nurses and a supervising care worker were on duty although none had defined supervisory roles. Due to the inconsistent level of supervision, suitable care was not assured, for example, there was no monitoring of fluid intake by staff for residents who had an identified specific fluid requirement.

In addition it was noted that there were inadequate staff on duty to supervise residents and meet their social and other holistic needs. Inspectors observed residents sitting for long periods without supervision, social or leisure involvement and company.

There was no schedule in place for staff training in 2014. Mandatory training was being provided, but there was no plan to make other training available to staff based on assessed training needs. Some care staff had attended training in care of older persons while others had not.

**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:***

Jackie Warren  
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>	Aras Chois Fharráige
<b>Centre ID:</b>	OSV-0000382
<b>Date of inspection:</b>	04/09/2014
<b>Date of response:</b>	11/10/2014

### 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 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The governance and management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored.

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

**Action Required:**

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

In ensuring that governance and management systems are in place to provide a service that is safe, appropriate, consistent and effectively monitored, the registered provider has extended an offer of employment to a new Person in Charge which she has accepted, and the Registered Provider has received satisfactory references. The garda vetting form has been submitted and is in process. This person will begin in the role as soon as thereafter. One NF30 was requested from the Authority to-day to notify the Authority: (i) of the resignation of the existing PIC and (ii) of the pending appointment of the new PIC.

The registered provider has requested two NF31s from the Authority to-day to notify the authority: (i) of the appointment of a new CNMII and (ii) of the appointment of a new CNMI. The CNMII will take up this position as soon as the new PIC is in situ. The new CNMI will take up this position with immediate effect.

**Proposed Timescale: 22/10/2014****Theme:**

Governance, Leadership and Management

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

There were limited systems in place to review and monitor the quality and safety of care and the quality of life of residents for the purpose of learning and improving the service.

**Action Required:**

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

The Registered Provider will ensure that the following will be completed before 22nd October: Restraint audit, pressure ulcer audit, falls audit, medication management, staff files; the centre staff will be involved in the auditing process.

The Registered Provider has ensured that a full health and safety assessment and audit was completed. The recommendations will be implemented in line with the timeframes allocated in the report.

In accordance with SI 415, Part 7, 23(d) the Registered Provider will have an annual review of the service for year ending 31st December 2014 completed by 31st January

2015.

There will be a complete audit and monitoring system in place by 31st December 2014. This will include both weekly monitoring and regular audits of clinical practice/ health & safety. Following training on auditing processes etc. the Registered Provider together with the PIC and senior staff will undertake these audits. The auditing system has commenced and for example a medication audit and a staff files audit is complete.

The new Person in Charge, when in place, will undertake a staff training needs analysis.

**Proposed Timescale: 22/10/2014**

### **Outcome 05: Documentation to be kept at a designated centre**

**Theme:**

Governance, Leadership and Management

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

There was no policy for staff training and development.

Policies contained insufficient information to guide practice and some were not centre specific.

There was a lack of consistent version control in the policies in use resulting in varying versions of policies being made available to staff.

**Action Required:**

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

The Registered Provider recognises his responsibilities under Regulation 04(1) and will ensure that, as per Schedule 5, the centre has written policies and procedures on the twenty matters outlined in Schedule 5. The Registered Provider, PIC and Centre staff will be involved and engaged in this to ensure that these policies are centre specific and conducive to the needs of residents of the centre.

There is a restraint register in place.

All policies will be reviewed, rewritten, centre specific and ratified by:

GROUP 1 – To be complete by 22nd October:

- The prevention, detection and response to abuse (No. 1)
- Staff Training & Development (No. 8)
- Medication Management (No.18 &19)
- Responding to Emergencies (No. 16)
- Fire Safety Management (No. 17)

- Infection Control (Appendix B)
- The handling and investigation of complaints (No. 20)

GROUP 2 - To be complete by 21st November:

- Admissions (No. 2)
- Risk Management (including the unexplained absence of a resident, accidental injury, aggression & violence; self-harm) (No. 15)
- Management of Behaviour that is Challenging (No. 3)
- Residents Personal Property (No. 5)
- Communication (No. 6)
- Recruitment, Selection & Vetting of Staff (No. 9)
- The creation of, access to, retention of and destruction of records (No. 12)

GROUP 3 - To be complete by 19th December:

- End of Life Care (No. 7)
- Use of Restraint (No. 4)
- Monitoring & Documentation of nutritional intake (No. 10)
- Provision of information to residents (No. 11)
- Temporary absence and discharge of residents (No. 13)
- Health and safety of residents, staff and visitors (No. 14)

The Registered Provider will have a system in place for reviewing, and controlling policies to ensure that there is only one copy of each policy in use at any given time. There will be a list of all policies with a creation and review date. The Registered Provider will review this list to ensure that all Schedule 5 policies are reviewed as per SI 415. In accordance with Regulation 04(2), these policies will be made available to staff.

**Proposed Timescale:** 22/10/2014

**Theme:**

Governance, Leadership and Management

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

Suitable records of residents' plans of care, medication errors, health care assessments and use of restraint (bed rails) were not being maintained as required by schedule 3 of the Regulations.

Some staff recruitment files did not include much of the required information such as two written references, a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, documented evidence of relevant training and a recent photograph.

**Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

Schedule 2 - A full staff file audit will be complete by 12th October, letters will be sent to staff on 24th October identifying any documents that may not be in their files and staff will be expected to return the documents before 30th November.

Schedule 3 – A new comprehensive assessment and care plan has been developed and all nursing staff have received training both on the implementation of the care plan and accountability and legislative requirements in terms of documentation. This took place over four days of intensive one to one and small group sessions for all nurses, to include use of the newly formatted care plan in practice. The new care plan includes the following health care assessments (not exhaustive):

- A bed rail risk assessment
- An assessment for lap belt and tilt chair
- Falls risk
- Pressure ulcer risk assessment
- MMSE
- Depression monitoring
- Wander/Elopement risk assessment
- Behaviour monitoring charts
- Sleep diary
- Smoking risk assessment

The above project involves a complete review, re-assessment and updating of the new comprehensive care plan and assessment framework for all residents. We plan to have at least 25 care plans completed by 22nd October and have prioritised those identified on inspection. There will be a reviewed and updated individual assessment and care plan in the new format complete for each resident by 21st November.

Medication errors identified during inspection were corrected promptly and the errors recorded in the medication errors log. The PIC and nursing staff will in future carry out regular monitoring of medication to ensure best practice and identify potential errors, gaps in the system.

Schedule 4 – The Registered Provider will ensure that all documentation as required per Schedule 4 will be kept in the centre. These will all be reviewed to ensure that they are accessible and stored and maintained appropriately – ongoing.

Nursing staff have had training on medication management – complete (26th Sept). All nursing staff have completed an online medication management programme.

All nurses have had documentation/care plan training.

**Proposed Timescale: 22/10/2014**

## 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:**

Adequate processes were not in place to manage behaviours that were challenging. Behavioural charts had not been initiated or care plans developed in line with the guidance of the centre's policy.

Staff had not received up to date training in management of behaviours that challenged.

**Action Required:**

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

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

All staff will have had training in managing behaviours that challenge by 31st December.

Behaviour charts will be initiated and care plans will be developed for all residents who present with behaviour that may be considered challenging.

The practice will be reflective of the managing challenging behaviour policy which will be completed by 30th November.

**Proposed Timescale: 22/10/2014**

**Theme:**

Safe care and support

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

The elder abuse policy did not provide guidance in all aspects of detecting, reporting and investigating suspicions or allegations of abuse.

The person in charge was not sufficiently clear on how an allegation or suspicion of abuse would be investigated and some staff were not sure what constituted abuse.

The restraint policy did not provide sufficient information to guide staff on the assessment and use of restraining devices, such as, bed rails, lap belts and tilted chairs.

The reasons for the use of bed rails or tilted chairs had not been assessed and appropriate risk assessments had not been undertaken.

There was no evidence that staff had received training in management and assessment of restraint.

**Action Required:**

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

The elderly abuse policy will be reviewed and will provide guidance on all aspects of detecting, reporting and investigating suspicions or allegations of abuse, as per outcome 2.

The Registered Provider will ensure that the Person in Charge is clear on how an allegation or suspicion of abuse will be investigated and will ensure that all staff know what constitutes abuse.

All staff will attend elderly abuse training update before 30th November.

The restraint policy will be reviewed as per outcome 2. The Registered Provider will ensure that it is reflective of the national guidelines towards a restraint free environment and will ensure that the restraint policy guides staff on the assessment and use of restraining devices.

The new comprehensive care plan does contain risk assessments for the use of bed rails or titled chairs and these will be done on all residents. 40% are complete to date. All care plans will be complete by 21st November.

All staff will have training in the management and assessment of restraint by 30th November.

**Proposed Timescale:** 22/10/2014

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

**Theme:**

Safe care and support

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

There was insufficient hazard identification and control in relation to absconsion, smoking, manual handling and access to dangerous materials.

**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:**

The risk management policy will be complete by 14th November. The risk register has been reviewed by an external consultant, in consultation and conjunction with the Registered Provider.

All staff are currently undertaking an online training programme in manual handling and will have completed by 22nd October.

A missing persons drill will take place on a monthly basis.

A smoking risk assessment tool is a part of the new care plan documentation. All care plans to be completed by 21st November.

The Registered Provider will ensure that there is a safe system in place for the management of dangerous materials – complete.

A meeting took place on 9th October with the cleaning product suppliers, and, the Registered Provider will ensure that there is current COSHH and data protection sheets for all products.

The missing persons box is complete. The fire documentation box is complete.

Furniture without fire certification have been removed. Matches are no longer in use. Lighters are to be kept in the office. A metal bin with lid for emptying ashtrays has been provided and a fire blanket put in place in the smoking room. Smoking policy/guidelines will be on display in the smoking room by 11th October.

A full health and safety risk assessment was carried out on 13th Sept and 16th Sept, the report will be reviewed and actioned when it is made available from the health and safety consultant to the registered provider.

**Proposed Timescale:** 12/09/2014

**Theme:**

Safe care and support

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

The systems in place to control the spread of infection were not adequate.

There was no infection control policy.

There was no guidance or training for staff on sanitising bed pans and commodes.

There was no protocol around how multi-tasking, (staff were involved in both resident care and housekeeping duties in the same shift) would be managed to prevent the risk of cross-infection.

**Action Required:**

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

The Registered Provider will ensure that an infection control and housekeeping audit will be completed by 19th October and in turn an Infection Control Policy will be written, ratified and implemented by 22nd October. Staff have had guidance on sanitising and safe practices.

The housekeeping department has been reviewed and a 1.75 WTE person has been assigned exclusively to cleaning duties and the Registered Provider will ensure that there are protocols in place should there be occasion where care staff need to carry out house-keeping duties - 20th October.

**Proposed Timescale:** 05/10/2014

**Theme:**

Safe care and support

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

Some staff members, including one who sometimes held responsibility during night shifts, did not have sufficient understanding of how residents would be evacuated in the event of an emergency.

**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:**

As an immediate response to the action plan the Registered Provider implemented an in house fire awareness training system which commenced on 6th September and has been ongoing since.

An external fire safety trainer has conducted safety awareness training on 10th Sept, 13th Sept and another session is planned for 17th Oct. A weekly no notice live fire alarm drill is now taking place.

**Proposed Timescale:** 09/09/2014

## 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 medication was not suitably stored. There was no process for dating products with an specified shelf life to ensure that the date of minimum durability was not exceeded after opening.

**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:**

All medications are now suitably stored and products with a specified shelf life have labels which indicate opening dates.

A meeting was held on 10th October with the pharmacist and a monitored dosage system will be introduced. The pharmacist is currently reviewing his operations and will need to make adjustments to meet the needs of the centre and once a date has been agreed we will notify the Authority.

**Proposed Timescale: 09/09/2014**

**Theme:**

Safe care and support

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

Some medication management and administration practices were unsafe. For example, a medication prescribed for night administration was being administered in the mornings.

**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:**

Nursing staff have attended medication management training on 12th Sept and 26th Sept. All nurses have completed an online medication management training programme.

There will be an ongoing audit programme and monitoring of medications which will be fully operational by November end. The nursing staff and PIC will carry out this process.

The medication management policy will be reviewed 22nd October.

**Proposed Timescale:** 09/09/2014

**Theme:**

Safe care and support

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

Out of date medicinal products was inappropriately stored.

**Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

As an immediate precaution the Registered Provider ensured that the out of date medication was returned to pharmacy and any out of date medicinal products will now be stored appropriately and returned to the pharmacy as soon as possible.

**Proposed Timescale:** 09/09/2014

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

**Theme:**

Effective care and support

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

A comprehensive assessment to inform appropriate care plans for each residents' health, personal and social care needs had not been arranged.

**Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

A comprehensive nursing assessment and care plan has been developed specifically for the centre which does inform appropriate care plans for each resident's care needs. 40% are complete to date. All care plans will be complete by 21st November.

**Proposed Timescale: 05/10/2014**

**Theme:**

Effective care and support

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

Care plans viewed were not completed in sufficient detail to guide staff in the delivery of care.

**Action Required:**

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

40% of the nursing assessments using the new documentation are complete. 100% will be complete by 21st November and these will be completed in sufficient detail as to guide staff in the delivery of care.

**Proposed Timescale: 05/10/2014**

**Theme:**

Effective care and support

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

Each resident's wellbeing and welfare was not maintained by a high standard of nursing care. Evidence based nursing care was not provided in the areas of falls, nutrition, dysphagia, epilepsy, wound care and follow through of health care issues.

**Action Required:**

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

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

The Registered Provider will ensure that all well-being and welfare will be maintained by high standards of nursing care. Evidence based nursing care will be provided in all areas including: falls, nutrition, dysphagia, epilepsy, wound care and all health care issues will be followed through.

Falls management training was conducted 29th Sept. the SALT attended the centre on 15th Sept and reviewed those residents with nutritional problems. Care plans were updated and reviewed in accordance with the recommendations and some residents were reviewed and no changes were recommended. There will be a quarterly audit of all nursing assessment and care plans first to be conducted March 2015 (four months

following the final completion of all care plan documentation on 21st November)

**Proposed Timescale:** 19/09/2014

### **Outcome 13: Complaints procedures**

**Theme:**

Person-centred care and support

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

Details of the investigation into the complaint, the outcome and complainant's level of satisfaction with the outcome was not recorded in one of the registers in accordance with the requirements of the Regulations.

**Action Required:**

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

The Registered Provider will ensure that all complaints are detailed and will ensure that the details of the investigation, the outcome and the complainants level of satisfaction will be recorded. The complaints policy has been corrected to ensure full compliance. A suggestions box has been placed in the reception area and there will be a workshop on the managing of complaints.

**Proposed Timescale:** 05/10/2014

### **Outcome 15: Food and Nutrition**

**Theme:**

Person-centred care and support

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

Meals were not provided to some residents in line with the recommendations of dietetic and speech and language therapists and some residents were not appropriately seated at mealtimes, which placed them at risk.

**Action Required:**

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

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

Each resident will be provided with adequate quantities of food and drink in line with the recommendations of dietetic and speech and language therapist. All residents are now being provided with food and drink to meet their assessed dietary needs.

All residents will be appropriately seated at mealtimes.

The new comprehensive care plan includes shared diet request sheet. These will all be completed by 21st November. Nutrition committee and lead nurse for nutrition will be implemented and operational by 21st November.

**Proposed Timescale: 09/09/2014**

**Theme:**

Person-centred care and support

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

The provision of suitable alternatives to residents with special dietary needs required improvement. These residents did not have the same choices of desserts, confectionery and baked products as other residents.

**Action Required:**

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

A SALT review was carried out on 15th Sept, care plans updated to reflect the recommendations. The menu has been redesigned to offer greater choice.

A colour coded tray labelling system has been introduced.

**Proposed Timescale: 05/10/2014**

**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:**

All residents did not have the opportunity to participate in recreational activities suited to their abilities. There was no plan to deliver appropriate recreational activities or stimulation to residents with dementia and cognitive impairment.

**Action Required:**

Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

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

There is an activities co-ordinator who has attended sensory enhancement training for people with dementia. She will be attending a Sonas training programme in January 2015. She will be delivering appropriate recreational activities and stimulation to residents with dementia and cognitive impairment – ongoing. She also is proficient in providing a programme called "Imagination Gym".

**Proposed Timescale:** 05/10/2014

**Theme:**

Person-centred care and support

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

The privacy screening arrangements in shared bedrooms were inadequate.

**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 four double rooms all have en-suite facilities where preferably residents will be encouraged to use these when attending to personal care. The three rooms with fixed screens have now also free standing mobile screens to ensure that each bed space is completely private. One bedroom is not suitable for fixed screen because of the room layout, we are currently using free standing mobile screens and have sufficient to cover both beds areas at any one time.

**Proposed Timescale:** 22/10/2014

**Outcome 17: Residents' clothing and personal property and possessions****Theme:**

Person-centred care and support

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

Residents' clothing does not always get returned to them from the laundry. The labelling on some garments was not clear.

**Action Required:**

Under Regulation 12(b) you are required to: Ensure each resident's linen and clothes are laundered regularly and returned to that resident.

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

The Registered Provider will put in place a system whereby nominated staff members take responsibility for ensuring that clothes are labelled clearly. Residents will be asked at the residents committee meetings to ensure that clothes are labelled or given to a staff member for labelling before being placed in wardrobes. A foot note will also be placed on the meeting minutes template. As a result staff will endeavour to ensure that all clothes are clearly labelled and will ensure that clothes are returned to residents in a timely fashion.

**Proposed Timescale:** 05/10/2014

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

The staffing skill mix at certain times of day or night was not adequate to meet the needs of residents.

**Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

Staffing levels are being reviewed using an assessment tool and will be complete by 22nd October.

A new PIC has been offered and accepted a position (see outcome 2) and is ready to start immediately, once satisfactory garda vetting is secured.

A CNMII and a CNMI were appointed on 17th October and they will provide staff supervision.

All departments will be reviewed and staffing levels will be based on the care needs of the residents.

**Proposed Timescale:** 12/09/2014

**Theme:**  
Workforce

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

Staff did not have access to appropriate training.

**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:**

For the past four weeks (see actions taken above) staff had training in fire safety management, falls management, medication management, moving and handling, documentation/care planning, safe use of cleaning products. A training matrix will be complete by 22nd October and a programme of mandatory and non mandatory training will be developed to ensure that all staff have access to appropriate training – 22nd October.

**Proposed Timescale:** 22/10/2014

**Theme:**  
Workforce

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

Staff members were not supervised appropriate to their roles.

**Action Required:**

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Staffing levels are being reviewed using an assessment tool and will be complete by 22nd October.

A new PIC has been offered and accepted a position (see outcome 2) and is ready to start immediately, once satisfactory garda vetting is secured.

A CNMII and a CNMI were appointed on 17th October and they will provide staff supervision.

**Proposed Timescale:** 12/09/2014