

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Caherass Nursing Home
<b>Centre ID:</b>	OSV-0000411
<b>Centre address:</b>	Caherass, Croom, Limerick.
<b>Telephone number:</b>	061 600 930
<b>Email address:</b>	caherassnursinghome@mowlamhealthcare.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Mowlam Healthcare Limited
<b>Provider Nominee:</b>	Pat Shanahan
<b>Lead inspector:</b>	Gemma O'Flynn
<b>Support inspector(s):</b>	Mary Moore
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	45
<b>Number of vacancies on the date of inspection:</b>	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 to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

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

From:	To:
13 January 2015 09:00	13 January 2015 17:30
14 January 2015 07:45	14 January 2015 16:30

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 14: End of Life Care
Outcome 15: Food and Nutrition
Outcome 16: Residents' Rights, Dignity and Consultation
Outcome 17: Residents' clothing and personal property and possessions
Outcome 18: Suitable Staffing

**Summary of findings from this inspection**

This report sets out the findings of a two day announced inspection to inform a decision for the renewal of registration.

Caherass Nursing Home is a purpose built centre, on well maintained grounds, that can cater for 50 residents. It is located on the outskirts of the town of Croom, Co. Limerick.

As part of the inspection process, inspectors met with residents, staff members, the clinical nurse manager, the person in charge, the regional operations manager and the provider. The inspector observed practices and reviewed documentation such as

policies and procedures, care plans, medication management, staff records and accident/incident logs.

Residents told the inspector that they were happy living in the centre and that they felt safe there. Staff were able to demonstrate good knowledge of the residents' care needs when speaking with the inspector, however some improvements were required in the documentation of care plans. Major non compliance was identified in Suitable Staffing and Safe Premises. Non compliances were also identified in the following outcomes: Health, Safety & Risk Management; Health & Social Care Needs; End of Life Care and Residents' Rights, Dignity & Consultation.

These non compliances are discussed throughout the report and in the action plan at the end of the report.

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

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

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

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

The statement of purpose contained all of the information required by Schedule 1 of the Regulations and was reviewed annually.

**Judgment:**

Compliant

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

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There was a clearly defined management structure in place that identified who was in charge, who was accountable and what the reporting structure was. Staff who spoke with the inspector were able to demonstrate good knowledge of this system. There was a system in place to improve the quality and safety of the service and as such regular audits were undertaken. These audits were available to the inspector and included,

amongst others: Hygiene & Infection Control; Health & Safety; Care Standards and Medication.

The provider discussed how the quarterly quality and governance meetings would inform the development of the annual review of the quality and safety of care delivered to residents as required by the Regulations.

Regular meetings were held in the centre such as: nurses' meetings, relatives meetings, resident meetings and health & safety meetings. The dates of these were clearly displayed for the year ahead in the lobby area of the centre.

There was evidence of consultation with residents and relatives via resident satisfaction surveys and focus groups. However, it wasn't clear that the feedback obtained was acted on. For example, one request was that additional chairs were available for visitors. This issue was evident again in the feedback from the focus group and in the questionnaires received by the Authority prior to an announced inspection. The minutes of residents' meetings recorded feedback but there was no follow up documentary evidence to support that issues raised had been addressed. For example, one resident requested that the television channels be changed more often; another resident said that they found the evenings boring. However, on discussion, the person in charge was able to demonstrate how requests were followed through; for example; the provision of fold up chairs.

**Judgment:**  
Compliant

***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:**

A guide in respect of the centre was available in each resident's bedroom. The guide provided a summary of services and facilities and also outlined the procedures for complaints and the arrangements for visitors.

The inspector reviewed a sample selection of contracts of care that had been signed as per the Regulations. The contract set out the services to be provided and set out all fees to be charged to the resident. In some instances, the centre was awaiting the return of the signed contract, however documentation showed that efforts were being made to have same returned.

**Judgment:**  
Compliant

***Outcome 04: Suitable Person in Charge***

*The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**  
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The centre was managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of services within the centre.

The person in charge was a nurse with a minimum of three years experience in the area of nursing the older person within the previous six years. She was able to demonstrate good clinical knowledge of the residents in the centre and had sufficient knowledge of the legislation and her statutory responsibilities.

Residents and relatives who spoke with the inspector were easily able to identify her as the person in charge and told the inspector that she visibly present in the centre on a daily basis. Residents and staff were supportive of the person in charge and told the inspector that she was approachable as a manager.

**Judgment:**  
Compliant

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

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

**Theme:**  
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

There were centre-specific policies that reflected the centre's practices and met the requirements of the Regulations. Records were kept securely and up-to-date and were easily retrievable. The records listed in Schedules 2,3 and 4 of the Regulations were in place; however there were occasions whereby the resident's care plans required further development to fully reflect the centre's practice and the knowledge of the staff. For example, the care plan for a resident with specific elimination needs required some additional information to fully guide staff. The care plan for another resident with specific mobility needs, required further information regarding the number of staff required to assist with a transfer.

Documentation relating to fire drill practices required development. It was not clear what issues had arose during the drill and therefore records did not enhance learning opportunities to assist with improving staff and residents' responses to fire drills. This is discussed in further detail under outcome 8.

The centre was adequately insured as required by the Regulations.

**Judgment:**

Substantially Compliant

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

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

Staff spoken with confirmed that there was no reported absence of the person in charge of a duration that required notification to the Authority and there were arrangements in place for the management of the designated centre during her absence. A new clinical nurse manager (CNM) had been recruited in March 2014; the CNM worked full-time including one weekend a month. She was suitably qualified and had established management experience prior to her appointment. The CNM was found to be fully conversant with the needs of each resident and the delivery of services. The CNM confirmed that she had been facilitated by the provider to undertake further education following her appointment so as to better assess and meet resident needs. The CNM was willing to deputise for the person in charge, was fully aware of the responsibility it entailed and had assumed responsibility for the service on two occasions to date.

However, there was evidence to support that the deficit identified in staffing impacted on the governance structure and required the CNM to frequently undertake the role of staff nurse on duty and/or to assume responsibility for the service in the absence of the person in charge while one of only two staff nurses on duty. This is discussed again in Outcome 18.

**Judgment:**  
Compliant

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

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

**Theme:**  
Safe care and support

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

**Findings:**

Inspectors were satisfied that there were measures in place to protect residents from being harmed or suffering abuse.

There was a suite of policies with a safeguarding component in place including policies on identifying, reporting and responding to any alleged, suspected and reported abuse; the management of challenging behaviours; the use of restraint including the use of psychotropic medication. Policies were seen to be kept under review and were signed as read by staff.

Training records indicated and staff spoken with confirmed their attendance at training on the protection of vulnerable adults; staff were aware of their reporting responsibilities and confident that any concerns raised would be appropriately dealt with by the person in charge. Inspectors spoke with residents throughout the inspection process and the feedback received from them was positive with staff described as "good" and "kind".

Policies and procedures were in place to safeguard residents' monies while facilitating ongoing access and control. The inspector reviewed these systems and was satisfied that policy was implemented by staff, records of all transactions were maintained by staff; receipts were available for items purchased or services provided and all records were signed by two staff members and/or the resident where possible. There were electronic records made available for inspection of the charges levied on residents including charges for additional services.

There was a low reported usage of physical restraint and this was confirmed on inspection. Inspectors saw that there was only one set of bedrails in use at the request

of the resident and that the minimal use of restraint was safely supported by evidence based policy; a risk balance decision making tool adapted from nationally agreed policy and the use of interventions such as low-low beds, impact reducing floor mats and movement alert devices.

A significant number of staff had attended education on the therapeutic management of challenging behaviours; records seen indicated an evidenced based approach to the management of behaviours that challenged. Residents, as appropriate to their needs, had ongoing access to services such as the community psychiatric nurse. The inspector reviewed care plans in place for responding to behaviour that challenged and saw that staff had sought to identify any possible antecedents to behaviours, The responses that alleviated behaviour, and those that did not and were to be avoided, were clearly outlined; staff spoken with were familiar with the plan.

However, one deficit was identified as inspectors noted that one resident demonstrated explicit behaviours that had the capacity to challenge; the behaviours had not been recorded in the basic admission assessment and the resident did not have a responsive behaviour plan in place. This non compliance is addressed in Outcome 11 Healthcare.

**Judgment:**  
Compliant

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

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

**Theme:**  
Safe care and support

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

No actions were required from the previous inspection.

#### **Findings:**

Overall, the inspector found that the health and safety of residents, staff and visitors was promoted and protected. However, improvements were required in the hazard identification process and in fire safety.

The centre had policies relating to health and safety and the safety statement had been reviewed in January 2014. There was a risk management policy in place that included all the items required in the Regulations except for the arrangements for abuse. The person in charge rectified this prior to the end of the inspection and the inspector was satisfied that it met the requirements of the Regulations. There was a comprehensive plan in place for responding to major emergencies likely to cause death, injury, serious disruption to essential services or damage to property.

The inspector noted that there was a recently employed housekeeping staff member in the centre, and although she was knowledgeable regarding the hygiene systems in house, the inspector noted that she had not received formal training in infection control

practices or hand hygiene practices. The person in charge stated she was aware of this and told the inspector that training was planned. However, no date had yet been allocated to ensure this training was delivered.

The inspector found that there was no clear system in place for ensuring that relevant infection control information was communicated in a timely fashion to the housekeeping staff. Staff told the inspector that the nurse would inform the housekeeping staff, however, the person in charge told the inspector that there was a daily communication book that would contain the relevant information. It was not evident that all staff knew to consult the communication book for such information.

There were arrangements in place for learning from adverse incidents involving residents. However, the inspector found that the hazard identification process was insufficient. On the days of inspection, hazards that had not been risk assessed were identified by the inspector, for example, bedroom fire doors were found to be propped open by chairs, footstools and shoes and therefore preventing the doors from containing a fire should one so occur. People moving and handling aids were seen to be stored on grab rails designed to support residents to walk independently in corridors thereby preventing residents from using the grab rail as they moved through circulation areas.

The doors on the first floor leading to stairwells had been fitted with an electronic lock system, however it had been decided that locks were not required on the ground floor doorways to stairwells. A risk assessment had not been undertaken in regards to these controls to ensure that they were sufficient to the identified risk.

The doors to assisted bathrooms on all floors were fitted with a coded locking system. The provider and regional operations manager stated that this was due to the risk of residents injuring themselves if left unsupervised in the these areas. However, there was no risk assessment completed to determine the level of risk and thus determining if controls were proportionate and/or sufficient to the risk outlined.

Staff were trained in manual handling and practices observed were seen to be in line with current practice.

There was suitable fire equipment available and service records indicated that they were serviced as required. Fire exits were unobstructed. Staff were trained and were able to clearly discuss what to do in the event of a fire. However, fire drills were not taking place at regular intervals and documentation of fire drills that had taken place required improvement to fully enhance learning opportunities from such drills.

There was written confirmation from a competent person that the legal requirements of the statutory fire authority were complied with.

**Judgment:**

Non Compliant - Moderate

**Outcome 09: Medication Management**

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that residents were protected by the centre's policies and procedures for medication management.

There was a policy in place relating to the ordering, prescribing, storing and administration of medicines to residents. The process for handling medications including controlled medicines was in line with current professional guidelines and legislation.

Medications were stored securely and arrangements for accessing controlled drugs were robust. The inspector observed a medicine round and practice was found to adhere to appropriate medication practices. There were suitable arrangements in place for the return of unwanted or out of date medication.

There was evidence that regular medication competency audits of nursing staff were undertaken by the person in charge. Medication audits were undertaken by the centre and also by an external pharmacist.

Pharmacists were facilitated to meet their obligations to residents and the inspector observed signs on the notice board of the lobby area advising residents of the next time and date the pharmacist would be on site. Records of these pharmacist visits were maintained.

**Judgment:**

Compliant

**Outcome 10: Notification of Incidents**

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

A record was maintained of incidents occurring in the centre and notifiable incidents were reported as required. Quarterly reports to the Chief Inspector were submitted as per the Regulations.

**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):**

No actions were required from the previous inspection.

**Findings:**

While deficits were identified in the process of care planning inspectors were satisfied that residents' healthcare requirements were met to a good standard. There was evidence to support that residents' healthcare requirements were adequately and regularly assessed by competent nursing staff and that arrangements were in place to meet assessed needs. Deficits pertaining to insufficient documentation were actioned in Outcome 5: Documentation to be kept at a designated centre.

On admission residents were facilitated to retain access to their general practitioner (GP) of preference. Staff reported that approximately five GP's attended the centre and medical records seen supported access to timely and responsive medical review. There was further documentary evidence that residents, as appropriate to their needs, had access to other healthcare professionals and services including dietetics, speech and language therapy, occupational therapy, psychiatry, chiropody and physiotherapy; the latter was seen to be provided weekly in the centre. Further arrangements were in place to facilitate optical and dental review. There was evidence of seasonal influenza vaccination. Nursing staff were suitably qualified to undertake venepuncture: there was evidence of regular blood profiling as a means of evaluating well being and managing treatment regimes.

The inspector saw that each resident had a nursing plan of care. A computerised system of care planning was used and a key-nurse system for care plan completion was in place. The inspector reviewed a random sample of care plans and was satisfied that the system was clearly understood by staff and the general standard of care planning was good. There was evidence that each care plan was informed by assessment and reassessment as required and at a minimum four monthly intervals.

Care plans were completed in consultation with the resident and/or their representative and were supported by a suite of validated assessment tools. In general care plans were person centred, clearly set out the arrangements to meet identified needs as specific to each resident and incorporated interventions prescribed by other healthcare professionals. However, as discussed in outcomes 7 and 14, deficits were identified in the process of care planning and all care plans seen did not reflect the knowledge that staff had on speaking with them of each resident's choices, needs and care requirements.

There was a low reported incidence of wounds. The inspector saw that the risk of wound development was regularly assessed. Preventative strategies including pressure relieving equipment were implemented. The inspector saw that the approach to wound management was evidence based; wounds were measured and graded and supported by photographic evidence; treatment regimes were informed following consultation with other healthcare professionals. Nursing staff had also completed wound management education.

A validated assessment tool was used to establish each resident's risk of falling and there was evidence of the routine implementation of falls and injury prevention strategies including the use of hip-protectors and movement alarm mats. The resident's right to refuse treatment was respected and recorded and brought to the attention of the relevant GP.

There were procedures in place and records seen supported that relevant information about the resident was provided and received when they were absent or returned to the centre from another care setting.

**Judgment:**

Compliant

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

Inspectors found that the design and layout of the centre was in line with the statement of purpose, however, issues relating to the number of showers available to residents had not been addressed (four showers to 50 residents), despite the provider's undertaking to do so by January 2012. This issue was discussed with the provider at the feedback meeting, who told inspectors that extending the number of showers available to residents was not a priority at this time.

Whilst inspectors found that the layout promoted dignity and well-being, inspectors found that the doors to assisted bathrooms were locked with a key-code pad, meaning that residents were not able to access the facilities without a member of staff present. The provider told inspectors this was done for health and safety reasons, however, there was no risk assessment available for review on the day of inspection, to demonstrate that these controls were proportional to the identified risk.

The premises and grounds were overall well maintained, however, some areas required superficial decorative upgrade. The person in charge showed the inspector her maintenance plan for 2015 and these issues were addressed.

Overall, the centre was homely, although some communal areas required additional touches to complete the homely feel, such as the day room on the second floor. The communal spaces were relatively small considering the number of residents in the centre. Residents were seen to have access to a quiet room and observed using this room on both days of the inspection. The quiet room also doubled as a visitor room, however, if the quiet room was in use by residents, there was no additional space for visitors.

The size and layout of bedrooms was suitable to meet the needs of the residents and each room had an en suite toilet and hand-wash basin. Each bedroom had the required furniture and residents were facilitated to add their own homely touches to their bedrooms. There was suitable storage for residents' belongings.

Residents had access to safe, external grounds that were well maintained. There was a functioning call bell in place and staff answered the bells in a timely fashion on the days of inspection. A working elevator was maintained. A separate kitchen with sufficient cooking facilities and equipment was in place.

Residents had access to appropriate equipment that was fit for purpose and for which service records were up to date. Handrails were provided in circulation areas and grab rails were provided in shower and toilet areas.

**Judgment:**

Non Compliant - Major

***Outcome 13: Complaints procedures***

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

<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Inspectors were satisfied that there were effective systems in place for the management of complaints.</p> <p>There were legislatively compliant policies and procedures in place and the procedure was prominently displayed in the main entrance hallway. Staff spoken with were familiar with the procedure for receipting and recording complaints. Residents spoken with said that they had no cause to complain but if they had, they would complain.</p> <p>The inspector reviewed the complaints records and saw that residents or persons acting on their behalf did raise matters of concern to them; these matters were investigated, remedial action was taken, feedback was provided and complainant satisfaction was established. There was evidence that any actions required for improvement were communicated to staff as relevant and were implemented. There was evidence that oversight of complaints and their management was maintained by the wider organisation as outlined in the policy.</p>
<p><b>Judgment:</b> Compliant</p>

<p><b><i>Outcome 14: End of Life Care</i></b> <i>Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.</i></p>
<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> No actions were required from the previous inspection.</p> <p><b>Findings:</b> Improvement was required in advance planning for end of life care and in supporting staff to acquire the necessary skills and confidence to initiate end of life care discussions with residents and relatives.</p> <p>There were end of life policies and procedures in place signed as reviewed in June 2014. Further minor review and amendment was required however as it did not fully provide clear direction for staff on the procedure for caring for the remains of the deceased resident.</p>

There were no apparent challenges to the provision of privacy and dignity at end of life as all resident accommodation with the exception of one room was provided in single bedrooms. Staff said that relatives were facilitated to remain with the resident at all times and that staff attended to their needs and comforts. There was documentary evidence that residents had access to timely medical review and that as appropriate end-of-life care was guided by specialist palliative care services.

Staff were aware of the religious denomination and choices of residents; mass was said weekly in the centre and the sacrament of healing was administered on a regular basis to residents who wished to receive it.

There were procedures in place for the management of sudden and unexpected deaths. Training and certification of staff in basic life support and AED was provided and staff were clear on the action to be taken in the absence of an explicit decision to not attempt resuscitation. The inspector saw signed dated records to support the clinical decision making process including the resident and/or relative, nursing staff and the relevant GP.

Policies and procedures were in place for the verification; confirmation and notification of deaths to all appropriate persons including the local coroner and staff spoken with were familiar with and confirmed implementation of these procedures. Staff were seen to have sourced a discreet bag for the return of personal property.

However, the arrangements in place to elicit and record residents' end of life choices and preferences were not sufficient. Staff spoken with described practice that ensured that the resident and their families received care that was appropriate to their needs and supported a dignified and comfortable death. The inspector saw that staff sought to elicit and record end of life care discussions with some residents and families. However, based on a sample of care plans reviewed including those with a clearly identified palliative care requirement, there was no care plan seen that clearly reflected residents individual needs, choices, preferences and wishes and that was sufficient to fully inform and direct the care to be delivered.

At the time of this inspection two staff nurses were undertaking post graduate education in end of life/palliative care; nineteen staff had attended end of life education in 2013; the attending pharmacist had also recently completed education in palliative care medication. However, the staff training matrix indicated and the person in charge confirmed that a significant number of staff employed had no recorded attendance at end of life education. Staff spoken with accepted that some staff found it difficult to communicate effectively with residents and relatives on matters relating to end of life care.

Both of the failings as identified in staff training and care planning had also been identified at the time of the last inspection.

**Judgment:**  
Non Compliant - Moderate

**Outcome 15: Food and Nutrition**

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Care was guided by a suite of evidence based policies. The inspector was satisfied that policy was implemented in practice and residents' needs were appropriately met. The deficits identified at the time of the last inspection had been satisfactorily addressed.

All meals were freshly prepared on site on a daily basis. There was documentary evidence that the catering facility was monitored by the relevant Environmental Health Officer (EHO). The inspector saw adequate and varied stocks of dry, fresh and frozen food stuffs. Catering staff spoken with confirmed that residents were consulted with and that their feedback, choices and preferences informed the choice and variety of meals provided.

The menu was clearly displayed and offered choice at each main meal. Staff were seen to ascertain each resident's meal preference. Residents requiring diet of a modified consistency were offered the same meal choices but in the required format. Portion sizes were adequate; meals appeared nutritious and wholesome, were presented in an appealing manner and were seen to be enjoyed by residents.

The feedback received from residents was positive and residents confirmed that the meals provided were always "good". The social dimension of meals was encouraged and two dining rooms were available and fully utilised with residents seen to be assisted by staff to come to the dining room for their meals. Two sittings were provided to facilitate residents who required staff assistance and supervision or simply extra time but the sittings were managed in a manner that integrated rather than segregated more dependent residents.

Adequate and appropriate staff supervision and assistance was noted to be available for residents on both days of inspection. However, the staffing deficits identified and discussed in Outcome 18 are of concern to inspectors as some recorded staffing numbers would not be sufficient to meet the needs of residents at all times.

The inspector saw that fluids and snacks were provided to residents at reasonable times and that residents were facilitated with a late breakfast if this was their choice. Fresh drinking water was also available.

Based on a purposeful sample of care plans the inspector was satisfied that procedures were in place to ensure that the needs of residents at risk or with specific requirements

were met. Residents were weighed at a minimum monthly and a validated nutritional risk assessment tool was used.

There was documentary evidence that staff monitored the findings of assessments and sought further intervention including GP and dietetic review and speech and language assessment as appropriate. There was a formal system of communication between nursing staff and catering staff and both disciplines were fully conversant with residents' dietary requirements.

Clear and specific nutritional care plans were in place. The instructions of other healthcare professionals were incorporated into the care plan and the plan was reviewed and updated in line with each resident's changing requirements. The care delivered as seen by the inspector was in line with the care plan including the provision of nutritional supplements and food and fluids of a modified consistency.

There was a clear procedure in place for the administration of prescribed supplements by nursing staff and their usage was seen to have decreased from 40% at the time of the last inspection to approximately 17%.

There were procedures in place for monitoring fluid and dietary intake where a concern or risk had been identified. Staff spoken with said that fluid/dietary monitoring was not currently in use and there was no evidence to support that they should have been. The inspector reviewed the care plan of a resident previously identified as of nutritional risk and saw that the matter was satisfactorily resolved with weight gained and maintained but continued to be monitored by nursing staff.

Some residents had specific requirements in relation to managing their blood glucose levels. Care plans were in place, the adequacy of the care plan was monitored by point of care testing. Each resident had their own blood glucose monitoring equipment.

**Judgment:**  
Compliant

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

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

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

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

**Findings:**

The inspector was satisfied that residents were consulted about how the centre was planned and run. Details of upcoming residents' meetings were displayed on notice boards and occurred monthly. A resident satisfaction survey had been completed in November 2013 and a focus group consisting of 11 residents took place in September 2014.

Residents had the opportunity to exercise personal autonomy and choice, be it what hour they chose to get up or dine at or whether or not they partook in activities. Residents were facilitated to exercise their civil, political and religious rights. In-house voting took place in the centre and a member of the nursing staff told the inspector that the GP was involved in assessing competency.

Whilst there were facilities for recreation, events such as afternoon music were held in the downstairs dining room. There was no restriction on visit times.

Staff were observed delivering care in a dignified way that respected privacy, for example, by knocking on the resident's bedroom door and awaiting permission before entering.

There was an activities co-ordinator on duty for 20 hours per week. Her role was supplemented by people external to the centre providing in-house entertainment. Activities such as bingo, arts & crafts, hand massage and rosary were on offer in the centre. Activities specifically tailored to residents with dementia were also in place. The inspector observed very good participation in the afternoon activities which included sing songs and exercises. However, there were periods during the morning, in particular in the upstairs sitting room, whereby the inspector noted some very quiet times with little or no stimulation. This concurred with feedback from staff, resident & relative feedback and staff that the inspector spoke with.

**Judgment:**

Substantially Compliant

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

There were policies, procedures and facilities in place for the management and safeguarding of residents' personal possessions.

The person in charge confirmed that the majority of residents choose to avail of the laundry service provided; bed-linen was also laundered in-house.

The inspector saw that the laundry was adequately equipped with industrial standard equipment; sufficient space was available for the segregation of clean and soiled linen; adequate shelving was available. There were dedicated laundry staff and the laundry operated on a daily basis including weekends. Staff spoken with confirmed that they collected and returned personal clothing to each resident throughout the day and there was no issue identified by residents, relatives or staff with missing items of clothing. There was a system in place for labelling clothing.

Each resident was seen to be provided with adequate personal storage space including a secure space if required. Staff said and the inspector saw that a record of each resident's personal property was completed on admission and kept up-to-date in so far as was reasonably practicable. The records seen were signed by staff and the resident or their representative.

**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. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**  
Workforce

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

No actions were required from the previous inspection.

**Findings:**

Whilst on the day of inspection, there was a full complement of staff, inspectors were not satisfied that at all times, there were sufficient staff with the right skills, qualifications and experience to meet the assessed needs of the residents. For example, staff rotas showed that staff levels fluctuated on a daily basis, meaning that at times, residents were cared for without a full complement of staff.

Inspectors saw that due to staff shortages, the rota was not being completed in advance and there was a reliance on the current staff to fill the outstanding shift requirements. The staffing rota confirmed that there was a nurse on duty at all times.

The person in charge confirmed that there was staffing difficulties which she attributed to a recent increase in admissions. The rota also indicated that on the first day of inspection, one staff member worked 8am to 2pm and then returned to work 8pm to 8am on the same day due to staff requirements for the night shift. Staff spoken to confirmed that fluctuations in staffing levels.

There was an education and training programme available to staff and the training matrix indicated that staff were up-to-date with mandatory training. Staff spoken with told inspectors that they had access to a good range of training. However, a deficit was identified in the provision of end-of-life care training, specifically in initiating communication and discussion of end of life with residents and or family members. As discussed in outcome seven, a recently recruited housekeeping staff member had not received training in infection control practices or hand hygiene. The person in charge stated she was aware of this and that the training was planned for 2015, however, there was no confirmed scheduled date.

Staff spoken with were aware of the Regulations and the Standards and where to access them in the centre.

Inspectors were not satisfied that the arrangements for supervision of staff were robust. For example, the recruitment policy lacked specific guidance regarding appropriate time-frames for supernumerary status and although the person in charge spoke of local procedures, these were not implemented in all cases. Evidence indicated that a newly appointed health care assistant received some supernumerary hours as part of their induction, however some of these hours were spent with an already under-resourced team, therefore compromising the quality of the mentorship of the new staff member. The newly recruited health care assistant was then counted as part of the full staff without undergoing any formal competency assessment to ensure that they were suitable to be included as a full member of staff.

Up to date registration was seen for nursing staff. A sample of staff files were reviewed and overall, the requirements of Schedule 2 of the Regulations were met, however for one file seen, there was reference from the staff member's most recent employer as required by the Regulations. The person in charge demonstrated awareness of this and told inspectors that a request had been sent, however there was no documentary evidence of this.

Volunteer files were in order.

**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:***

Gemma O'Flynn  
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>	Caherass Nursing Home
<b>Centre ID:</b>	OSV-0000411
<b>Date of inspection:</b>	13/01/2015
<b>Date of response:</b>	16/02/2015

#### Requirements

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

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

#### Outcome 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 were occasions whereby the resident's care plans required further development to fully reflect the centre's practice and the knowledge of the staff.

Documentation relating to fire practices required development to fully reflect the practices in the centre.

<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 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:**

All care plans have been reviewed to ensure that they are person-centred and individualised, reflecting the specific care needs identified.

Fire drills are scheduled to take place on a bi-annual basis, and a record of these will be maintained in the centre. Documentation relating to the fire drills will include a review of the response and actions taken and will identify any problems or difficulties encountered and recommendations for future practice. The feedback from these fire drills will be circulated to all staff, and will be discussed at the Health & Safety Committee meetings and Quality & Governance meetings.

**Proposed Timescale:** 31/03/2015

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

Safe care and support

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

It was not clear that all controls in the centre had been thoroughly assessed to ensure their suitability and proportionality, for example: the locks on assisted bathroom doors and the controls in place on stairwell entry points.

**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:**

Risk assessments on bathrooms have been reviewed; the doors will remain locked when not in use as there are currently a significant number of residents who have a tendency to wander and are a high falls risk.

All stairwells have been risk assessed and 2 further keypad controls are to be fitted to ensure increased security of access to all stairwells.

**Proposed Timescale:** 28/02/2015

**Theme:**

Safe care and support

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

Not all hazards were identified, for example, bedroom doors being propped open at night with furniture or footwear.

**Action Required:**

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

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

All staff have been reminded of the importance of ensuring that all doors are closed and that they are never propped open. This will be reinforced during fire training sessions and at all staff meetings. Compliance with this will be monitored by the Person-in-Charge and designated safety representatives.

Electronic door guards will be installed on certain doors where appropriate.

**Proposed Timescale:** 31/03/2015

**Theme:**

Safe care and support

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

New household staff had not received training in infection control or hand hygiene. There was no clear system for ensuring effective communication between nursing and household staff of new infection control issues arising in the centre.

**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:**

Education on Infection Control and hand hygiene has been organised for 25/02/15 for relevant staff. Measures have been put in place to improve written and verbal communication between all staff groups as appropriate regarding infection control issues.

**Proposed Timescale:** 25/02/2015

**Theme:**

Safe care and support

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

Fire drills were not taking place at regular intervals.

**Action Required:**

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

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

The Fire Training Officer has recommended that fire drills are carried out twice a year. These will be documented and a review will be recorded, identifying any difficulties or problems that may arise during the fire drill, and recommendations for future practice. The fire drills will also be reviewed at Health & Safety Committee meetings and as part of the quarterly Quality & Governance meetings.

**Proposed Timescale:** 31/03/2015

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

Effective care and support

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

Issues relating to the number of showers available to residents had not been addressed (four showers to 50 residents), despite the provider's undertaking to do so by January 2012.

**Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

There are 4 showers and 1 assisted bath in the centre. Following a review the Person-in-Charge feels that this is an adequate number to meet the needs of the residents at the present time.

**Proposed Timescale:** 16/02/2015

#### Outcome 14: End of Life Care

**Theme:**

Person-centred care and support

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

The arrangements in place to elicit and record residents' end of life choices and preferences were not sufficient. Consequently, there was no care plan seen that clearly reflected residents individual needs, choices, preferences and wishes and that was sufficient to fully inform and direct the care to be delivered.

**Action Required:**

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

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

End of life care planning has been commenced for all residents. The documentation of end of life care wishes and plans will be in place for all residents by the end of March or as individual needs arise.

**Proposed Timescale:** 31/03/2015

#### 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:**

There were periods during the morning, in particular in the upstairs sitting room, whereby the inspector noted some very quiet times with little or no stimulation.

**Action Required:**

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

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

Some residents have indicated a preference to sit upstairs in a quiet area, reading newspapers or relaxing.

An additional Sonas programme per week has now been introduced, and a review of the Activities Programme will ensure that there is a variety of events and activities scheduled throughout the week.

**Proposed Timescale:** 28/02/2015

## Outcome 18: Suitable Staffing

**Theme:**  
Workforce

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

Staff rotas showed that staff levels fluctuated on a daily basis, meaning that residents were cared for without a full complement of staff.

**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:**

There are now 2 additional staff nurses in post and additional care assistants have been appointed.

**Proposed Timescale:** 28/02/2015

**Theme:**  
Workforce

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

A deficit was identified in the provision of end of life care training, specifically in initiating communication and discussion of end of life with residents and or family members.

Housekeeping staff had not received infection control 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:**

The training and education needs of all staff have been reviewed. End of Life training organised for 27/02/15 and Infection Control 25/02/15. Priority will be given to those staff who have not yet received training in these areas. The Person-in-Charge will be supported by the Practice Development Facilitator in the provision of education to staff.

**Proposed Timescale:** 28/02/2015

**Theme:**  
Workforce

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

Newly inducted staff did not always undergo a formal competency assessment prior to being counted as a full member of staff.

**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:**

Formal competency assessments will be undertaken for new staff on aspects of care, such as medication competency assessments for staff nurses. All staff will have regular individual performance reviews. The Person-in-Charge will be supported by the Practice Development Facilitator in ensuring that newly inducted staff undergo a formal competency assessment.

**Proposed Timescale: 31/03/2015**