<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Sullivan Centre</th>
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</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000494</td>
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<tr>
<td><strong>Centre address:</strong></td>
<td>Cathedral Road, Cavan.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>049 432 6000</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:pauline.townsend@hse.ie">pauline.townsend@hse.ie</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>The Health Service Executive</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Health Service Executive</td>
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<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Rose Mooney</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>PJ Wynne</td>
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<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
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<tr>
<td><strong>Type of inspection</strong></td>
<td>Announced</td>
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<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>19</td>
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<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>2</td>
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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.
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**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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</thead>
<tbody>
<tr>
<td>03 February 2015 09:30</td>
<td>03 February 2015 17:00</td>
</tr>
<tr>
<td>04 February 2015 09:15</td>
<td>04 February 2015 14:45</td>
</tr>
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</table>

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
<th>Outcome 02: Governance and Management</th>
<th>Outcome 03: Information for residents</th>
<th>Outcome 04: Suitable Person in Charge</th>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
<th>Outcome 06: Absence of the Person in charge</th>
<th>Outcome 07: Safeguarding and Safety</th>
<th>Outcome 08: Health and Safety and Risk Management</th>
<th>Outcome 09: Medication Management</th>
<th>Outcome 10: Notification of Incidents</th>
<th>Outcome 11: Health and Social Care Needs</th>
<th>Outcome 12: Safe and Suitable Premises</th>
<th>Outcome 13: Complaints procedures</th>
<th>Outcome 14: End of Life Care</th>
<th>Outcome 15: Food and Nutrition</th>
<th>Outcome 16: Residents' Rights, Dignity and Consultation</th>
<th>Outcome 17: Residents' clothing and personal property and possessions</th>
<th>Outcome 18: Suitable Staffing</th>
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</table>

**Summary of findings from this inspection**

This report set out the findings of a registration renewal inspection, which took place following an application to the Health Information and Quality Authority (the Authority) Regulation Directorate, to renew registration of the designated centre.

The inspector met with the provider, person in charge and staff members. A number of questionnaires from residents and relatives were received prior to the inspection and the inspectors spoke to residents during the inspection. The collective feedback from residents and relatives was one of satisfaction with the service and care provided.
The centre can accommodate a maximum of 16 residents who need long-term care and five residents for respite care needs. As outlined in the centre’s Statement of Purpose ‘the Sullivan Centres’ sole purpose is the care of older people primarily over the age of 65 years, who are mobile and have a diagnosis of dementia’. Therefore all residents accommodated have a condition which will progressively impair their capacity and are facing a situation in which loss or impairment of capacity is foreseeable.

The inspector found that residents were receiving responsive healthcare that met their assessed needs. Residents spoke positively about the food and people were supported to maintain a good diet. The physical environment met their needs, and residents enjoyed access to a safe enclosed garden. A range of activities were provided that people could choose to take part in.

The nurse management team and all staff interacted with residents in a respectful, warm and friendly manner. Staff demonstrated a thorough knowledge of residents’ needs, likes, dislikes and preferences.

There were clear systems in place for health and safety and risk management. There were also polices in place to guide staff in how to undertake their role effectively.

The minor areas identified for improvement are discussed further in the report and are included in the Action Plan at the end of this report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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:**
The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided.

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the Regulations. The statement of purpose is kept under review by the provider and had been updated in January 2014.

**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 defined management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre.

The person in charge attends meetings with the provider on a routine basis. There is a reporting system in place to demonstrate and communicate the service is effectively monitored and safe between the person in charge and the service provider.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge. A system of audits is completed on an annual basis to include clinical data in areas namely medication management, nutrition and any accident/falls sustained by residents and care planning practices.

The inspector found that this information was used to improve the service. Improvement plans to ensure enhanced outcomes for residents were developed. A care staff member is assigned since last year in the morning time to the day sitting room to monitor and assist residents.

The findings from audits and quality improvement strategies were collated into reports with copies made available to the residents or their representative for their information as required by the regulations. The outcomes of the meal time, hygiene and risk audit for the past month were displayed on the wall of the unit inside the main entrance.

However, the same areas were being audited repeatedly. The quality assurance program required further expansion to review additional areas which impact on resident’s wellbeing and quality of life.

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

Findings:
The inspector found that all residents accommodated had an agreed written contract. The contract included details of the services to be provided and the fees payable by the residents. The inspector reviewed a sample of three contracts of care. All contracts were
signed by relevant parties.

Separate contracts were in place outlining the terms and conditions for residents accommodated for respite care. The contract was signed each time a resident was readmitted to the centre.

There is a residents’ guide available containing the information required by the Regulation. This was revised as required by the action plan of a previous inspection. This was available in the entrance foyer and the day sitting room along with a copy of the Statement of Purpose and the most recent inspection report by the Authority.

The complaints procedure was displayed in the entrance lobby for visitors to view. This provided direction to the appropriate person they could raise an issue with if they had a concern.

There was an information display area with relevant brochures to provide age appropriate information to residents in relation to protection, finances and bereavement support.

**Judgment:**
Compliant

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**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 person in charge has not changed since the last inspection in May 2014. She is a registered nurse and holds a full-time post. She was well known by residents.

She facilitated the inspection well and provided all the information requested by the inspector in a timely manner. She demonstrated that she had good knowledge of the legislation and standards throughout the inspection. She was familiar with residents care needs.

There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge.

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

**Findings:**
The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner.

A sample of five staff files to include the files of the two most recently recruited staff were reviewed. The files were examined to assess the documentation available, in respect of persons employed. All the information required by Schedule 2 of the Regulations was available in the staff files reviewed.

A directory of residents was maintained. This is maintained electronically. The directory was updated since the last inspection. The cause of death when established was noted in the directory of residents. This was an area identified for improvement on a previous inspection.

**Judgment:**
Compliant

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

The Chief Inspector is notified of the proposed absence of the person in charge from the designated 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:
The provider is aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. There are clinical nurse managers nominated to deputise while the person in charge is absent.

The person in charge confirmed to the inspector they are rostered opposite each other to cover holidays.

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:
Residents spoken with stated that they felt safe in the centre. There was a visitors log in place and entrance and exit doors were monitored by CCTV. No notifiable incidents of adult protection which are required to be reported to the Authority occurred since the last inspection.

Staff to whom the inspector spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. There was an ongoing program of refresher training in protection of vulnerable adults in place.

There was an adult protection policy in place. Protected disclosure procedures to guide staff in their reporting of a suspicion of abuse were documented in the policy. Garda Síochána vetting had been applied for all staff members. This was evidenced by a review of returned Garda Síochána vetting forms examined by the inspector.

There was a policy outlining procedures to guide staff on the management of residents’ personal property and possessions. Residents’ finances were managed in line with the HSE, private property accounts procedures and subject to internal audit. Residents did
not hold any money on their person or in their bedrooms.

There is a policy on the management of behaviour that is challenging. Staff spoken with were very familiar with resident’s behaviours and could describe particular interventions well to the inspector for individual residents. Psychotropic medications used were pertinent to specific behaviours and observed to be closely monitored by the prescribing clinician and regularly reviewed to ensure optimum therapeutic values. Risk assessments and care plans for challenging behaviour were completed.

However, all staff were not trained in the management of behaviours that challenge. The majority of staff were last trained in 2010. Since this time there has been a high staff turnover and refresher training has not been provided. New staff recruited have not been trained in behaviours that challenge in line with the policy and procedures to ensure they have up to date knowledge and skills to respond appropriately.

A restraint free environment was maintained. There were no physical restraint measures (bed rails or lap straps) in use at the time of this inspection. Additional mattresses were placed by beds, sensor alarms, monitors and increased safety checks were in place for residents.

**Judgment:**
Substantially 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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The inspector was satisfied that the health and safety of residents, staff and visitors in the centre was promoted and protected. The actions in the previous inspection which related to risk, health and safety were satisfactorily completed.

The organisational safety structure in the documentation was updated to reflect the provider nominated. Access to plastic gloves and aprons located in dispenser units on the corridors and in bathrooms was secured in the interest of residents’ safety. A wash-hand basin and sink was provided in the laundry to minimise the risk of cross infection.

The risk management policy contained the procedures required by the regulation 26 and schedule 5 to guide staff.
The Authority was provided with written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire authority in relation to the use of the building as a residential centre for dependent older people in advance of this inspection.

Service records showed that the fire alarm system and the emergency lighting and fire equipment was serviced. The inspector read the records which showed that inspections of fire exits, the fire panel and fire fighting equipment was checked to ensure it was in place and intact.

Fire safety equipment including the fire alarm, fire fighting equipment, emergency lighting and smoke detectors were provided and were serviced quarterly and annually as required. The procedure to follow on hearing the alarm and the action to take on discovering were displayed around the building. Specialised equipment was available to assist in evacuating residents with impaired mobility. These were located at the corner of each corridor. There are no residents who smoke accommodated at the time of this inspection.

All staff except one newly recruited nurse had completed training in fire safety evacuation procedures. Further training dates were scheduled. Records indicated fire drill practices were completed. The fire drills records detailed the scenario/type of simulated practice, the time taken for staff to respond to the alarm and to evacuate. There was evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required as these were discussed at handover report between shifts. However, only two fire drills were completed within a 12 month period. All staff did not have an opportunity to actively participate in a fire drill practice in addition to their annual training.

There were procedures in place for the prevention and control of infection and hand gels were located around the building. Audits of the building were completed at intervals to ensure the centre was visibly clean. Hand gels are located outside each bedroom door. A separate cleaning and sluice room was provided.

There was a good cleaning system in place to break the cycle of infection and minimise the risk of cross contamination. Separate cleaning equipment and cloths were used to clean each bedroom and communal areas. There were a sufficient number of cleaning staff rostered each day of the week. Staff were able to explain how they cleaned a room in the event of an outbreak of infection in line with best practice.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a head injury. Individual strategies were outlined and utilised to minimise the risk of residents sustaining a fall to include, sensor mats placed on the floor outside beds and call bells placed close to residents. A post falls assessment was completed 24 hours in the aftermath of a fall by a resident.
The training records showed that staff had up-to-date training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. Each resident’s moving and handling needs were identified and available to staff at the point of care delivery in bedrooms. Three residents mobilised with a Zimmer frame and four with a walking stick. All other residents were either fully independent or required the assistance of one or two members of staff.

**Judgment:**
Substantially Compliant

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**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:**
There was a comprehensive medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident. The prescription sheets reviewed were legible and distinguished between PRN (as needed), regular and acute medication.

All medication was dispensed from individual packs which were delivered to the centre on a monthly basis by the pharmacy. On arrival the prescription sheets from the pharmacist were checked against the prescription sheet in the signed kardex and the medication delivered to ensure all medication orders were correct for each resident.

The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet. Medication that was discontinued was signed by the GP (general practitioner).

Medication was being crushed for some residents. Alternative liquid or soluble forms of the drugs were sought where possible through consultation with the pharmacy. Drugs being crushed were signed by the GP as suitable for crushing.

Medicines were being stored safely and securely in the clinic room which was secured. Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations.
Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. There was one resident on a controlled drug at the time of this inspection. The inspector checked the balances and found them to be correct.

**Judgment:**
Compliant

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**Outcome 10: Notification of Incidents**
*An 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:**
The inspector reviewed a record of incidents/accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required.

**Judgment:**
Compliant

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**Outcome 11: Health and Social Care Needs**
*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective care and support

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

**Findings:**
The arrangements to meet residents’ assessed needs were set out in individual care plans. The inspector found a good standard of evidence-based care and appropriate medical and allied health care access. Recognised assessment tools were used to evaluate residents’ progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure...
The inspector reviewed three resident’s care plans in detail and certain aspects within other plans of care to include the files of residents with nutritional issues, potential behaviour that challenges and those with a high risk of falls. The inspector found that all files reviewed were comprehensive. The range of risk assessments completed were used to develop care plans that were person-centred, individualised and described the current care to be given. In the sample of care plans reviewed there was evidence care plans were updated at the required intervals or in a timely manner in response to a change in a resident’s health condition. There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan when reviewed or updated.

Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. A review of residents’ medical notes showed that GP’s visited the centre regularly. The GP’s reviewed and re-issued each resident’s prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals to include speech and language therapist, dietetic service and physiotherapy was available. There was one resident with wound problem. A suitable plan of care was in place to guide staff to the type of dressing and frequency of changing. This was revised in accordance with the specialist advise from the ulcer clinic.

A new pain management policy was developed since the last inspection. A pain assessment chart was available for one resident wearing a patch for pain management. Two valid pain assessments tools were available for use. One for residents who can verbally express themselves and another for non verbal residents.

**Judgment:**
Compliant

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**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):**
The action(s) required from the previous inspection were satisfactorily implemented.
**Findings:**
The centre is a single-storey construction. It was purpose-built and designed to meet the needs of dependent persons. It was found to be comfortable and welcoming.

There is a high level of personalisation evident in residents’ bedrooms. Residents have a photo album memory book. While the majority of the bedrooms are less the size outlined in the Authority’s Standards they are presently meeting the needs of residents currently accommodated. There are a number of hoists of different sizes which can meet the moving and handling needs of residents within their bedrooms. All residents are mobile, while they require different levels of assistance from the use of walking frames to the assistance of one to two members of staff. Residents could choose from three different day rooms to sit in if they wished to move to a quieter environment.

Each bedroom is provided with a wash hand basin. Hand testing indicated the temperature of hot water did not pose a risk of scalds. The building was comfortably warm and radiators did not pose a risk of burn to touch. There were a sufficient number of toilets and showers provided for use by residents to include toilets located adjacent to the day room and dining room.

The design of the building internally had an open aspect allowing for continuous circular freedom of movement for residents to walk around the building and use the garden as they wish. Seating was provided at intervals along the corridors to allow residents sit and rest. This was useful for the smaller number of residents who actively circuited the building throughout the day.

Each bedroom door is brightly painted. All residents have their photograph on the door of their bedroom. Two residents hold the key to their bedroom which they like to keep locked. There is a courtyard garden which provides a safe, secure and accessible outdoor space.

Staff facilities were provided with space for the storage of personal belongings. Separate toilets and showering facilities were provided for care and kitchen staff in the interest of infection control.

However, not all parts of the building were suitably decorated. Paintwork on bedroom and hallway skirting boards were stained or marked. Decorative maintenance of woodwork in some parts of the communal areas to include the dining room required repainting. There were tiles missing from the area over the wash hand basin in bedroom numbered 48. The light cover and bulb were missing from the bathroom beside entrance to the nurse’s office. The door of the wardrobe in bedroom numbered 50 was coming loose from the hinges.

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

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

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

**Findings:**
There was a comprehensive complaints policy in place. This was revised since the last inspection as it was identified as an area for improvement. The person in charge explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure, unless the complainant wishes otherwise.

A designated individual was nominated with overall responsibility to investigate complaints. The timeframes to respond to a complaint, investigate and inform the complainant of the outcome of the matter raised by them were detailed. A nominated person who would monitor that the complaints process was followed and recorded (independent of the person responsible to investigate the complaint) was detailed in the complaints procedure.

There was an independent appeals process if the complainant was not satisfied with the outcome of their complaint. No complaints were being investigated at the time of inspection. A complaints log was in place which contained the facility to record all relevant information about complaints. There was evidence complaints were resolved to the satisfaction of the complainant.

**Judgment:**
Compliant

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**Outcome 14: End of Life Care**
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.

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

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
This outcome was the subject of a thematic inspection in May 2014 and all aspects of end of life were examined in detail during the inspection. The areas identified for improvement from the last inspection were reviewed during the course of this visit.

Resident’s end-of-life care preferences/wishes are now being identified and documented in their care plans. The policy of the centre is all residents are for resuscitation unless documented otherwise. At the time of this inspection there was one resident with a do not resuscitate (DNR) status. A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. The (DNR) status was reviewed to assess the validity of clinical the judgement on an ongoing basis.

Twenty staff had completed end of life care training between June and October 2014. This was an area identified for improvement on the last visit.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
This outcome was the subject of a thematic inspection in May 2014 and all aspects of food and nutrition were examined in detail during the inspection. The areas identified for improvement from the last inspection were reviewed during the course of this visit.

The evening time menu at the weekend was revised to offer residents an option of a hot course on all occasions within the three week rotating menu cycle.

All resident’s food and nutrition needs were detailed in a nutritional plan of care in files reviewed. Training on completing nutritional assessments was undertaken by the nursing staff.

The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff. Nutritional screening was carried out using an evidence-based screening tool at a minimum of three-monthly intervals. Each need had a corresponding care plan. All
Residents were weighed regularly.

**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:**
There was evidence of a very good communication culture amongst residents, their families, the staff team and person in charge.

Residents were dressed well and according to their individual choice. The inspector observed staff interacting with residents in a courteous manner and addressing them by their preferred name.

Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely.

Residents could practice their religious beliefs. Mass took place on a weekly basis.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by care assistants throughout the day.

There was a visitor’s room to allow residents meet with visitors in private.

Residents had access to a variety of national and local newspapers and magazines to reflect their cultural interests and heritage. These were located in easily accessible areas and available to residents daily. A residents’ forum was in place and regular residents meeting took place.

**Judgment:**
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:
Residents had adequate space for their belongings. Each resident was provided with their own wardrobe and bedside locker. The centre provided the service to laundry all residents’ clothes and families had the choice to take home clothes to launder if they wished.

A system was in place to ensure all clothes were identifiable to each resident. The inspector spoke to the staff member working in the laundry and she confirmed she undertakes repairs and alteration to clothes as required.

A property list was completed with an inventory of all residents’ possessions on admission and updated regularly. A list of resident’s personal possessions was maintained on the inside of their wardrobe.

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:
The provider employs a whole-time equivalent of 7.75 registered nurses and 26.35 care assistants and support staff. The inspector viewed the staff duty rota for a three week period. The rota showed the staff complement on duty over each 24-hour period. The person in charge at all times was denoted on the rota. The staff roster detailed their position and full name. The inspector noted that the planned staff rota matched the staffing levels on duty. There was an adequate staff complement with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre.

There was a detailed policy for the recruitment, selection and vetting of staff. It was reflected in practice. This was evidenced by a review of staff files. Recently recruited staff confirmed to the inspector they undertook an interview and were requested to submit names of referees.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on infection control, nutritional care and end-of-life care and cardio pulmonary resuscitation techniques. However, as identified under Outcome 7, Safeguarding and Safety, all staff were not trained in the management of behaviours that challenge.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
### Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Sullivan Centre</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000494</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>03/02/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>18/03/2015</td>
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### 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 same areas were being audited repeatedly. The quality assurance program required further expansion to review additional areas which impact on resident’s wellbeing and quality of life.

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1 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:**
A review of the current auditing is being undertaken in consultation with the Quality & Patient Safety Committee with a view to further developing our audit framework, the emphasis being on resident safety and quality of life issues.

**Proposed Timescale:** 04/05/2015

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### 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:**
All staff were not trained in the management of behaviours that challenge. New staff recruited have not been trained in behaviours that challenge in line with the policy and procedures to ensure they have up to date knowledge and skills to respond appropriately.

**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:**
1. Four staff members have been booked to attend the HSE 3 day National Dementia Programme. Also, additional Dementia specific training is in the process of being sourced externally for roll out across all staff within the service. Dementia Training – to be completed by 31st August 2015

2. A series of training dates for the Prevention & Management of Aggression & Violence have been arranged and training commenced on the 10th March. This training is based on a site specific assessment of need and delivered by a fully qualified instructor. PMAV Training – due to be completed for all existing staff by 28th April 2015

**Proposed Timescale:** 31/08/2015
| Theme: Safe care and support |
| The Registered Provider is failing to comply with a regulatory requirement in the following respect: |
| One newly recruited nurse had not completed training in fire safety evacuation procedures. |

**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:**
The one new staff member concerned received training on 6th March 2015. Further scheduled Fire Control & Evacuation training will continue to be provided to ensure that all staff training remains in date in accordance with statutory requirement.

**Proposed Timescale:** 06/03/2015

| Theme: Safe care and support |
| The Registered Provider is failing to comply with a regulatory requirement in the following respect: |
| All staff did not have an opportunity to actively participate in a fire drill practice in addition to their annual training. |

**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:**
Regular staff drills are now being undertaken on an ongoing basis to ensure that staff responses are in line with their training.

**Proposed Timescale:** 16/03/2015
**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:**
Paintwork on bedroom and hallway skirting boards were stained or marked. Decorative maintenance of woodwork in some parts of the communal areas to include the dining room required repainting.

There were tiles missing from the area over the wash hand basin in bedroom numbered 48.

The light cover and bulb were missing from the bathroom beside entrance to the nurse’s office.

The door of the wardrobe in bedroom numbered 50 was coming loose from the hinges.

**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:**
Maintenance has been completed on the tiling, light fitting and wardrobe door. The redecoration of the unit will be put out to tender in accordance with HSE National Funding Regulations.

**Proposed Timescale:** 31/08/2015