<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Support Care Facility Prague House</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000548</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Chapel Street, Freshford, Kilkenny.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>056 883 2281</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:srbridget1@gmail.com">srbridget1@gmail.com</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Freshford Social Services</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Bridget Lonergan</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Mairead Harrington</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>Louisa Power;</td>
</tr>
<tr>
<td><strong>Type of inspection:</strong></td>
<td>Announced</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>22</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>0</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.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>21 January 2015 10:30</td>
<td>21 January 2015 18:00</td>
</tr>
<tr>
<td>22 January 2015 09:45</td>
<td>22 January 2015 15:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

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

This was an announced inspection following an application by Prague House Supported Care Home, in accordance with statutory requirements, for re-registration of a designated centre. As part of the inspection the inspectors met with residents, the provider nominee and person in charge, the staff nurse and other staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The last inspection, on 8 October 2014, was a single issue inspection that focused on the outcome of medication management. A copy of that report and its findings, including the provider's response and action plan, can be found on www.hiqa.ie.
The findings of this re-registration inspection are set out under 18 outcome statements. These outcomes set out what is expected in designated centres and are based on the requirements of 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. The inspectors were satisfied that residents had access to the services of a general practitioner (GP) and other healthcare professionals on a regular basis. There was a variety of choice for residents in their day-to-day living with personal preferences accommodated as requested.

Areas for improvement were identified in relation to governance, training, medication management, premises, staffing and documentation. These issues are covered in more detail in the body of the 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 reviewed the statement of purpose which declared the aims, objectives and ethos of the centre and summarised the admission criteria, facilities available and services provided. The person in charge confirmed that the statement of purpose was kept under review though the current copy did not reference the conditions of registration or outline the arrangements in the event of the absence of the person in charge. This information was revised and incorporated at the time of inspection.

**Judgment:**
Substantially Compliant

### Outcome 02: Governance and Management

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The designated centre was operated on a voluntary basis with a well established system of governance in place via a board of management. In general the governance structure was supportive of both staff and the person in charge who reported effective on-going
communication as verified by a board member in attendance on occasion during the inspection. The role of both person in charge and provider nominee was fulfilled by a single individual volunteer, with the support of a nominated deputy - also a volunteer. In the week’s roster reviewed by the inspectors both volunteers were, between them, in attendance on duty for over 120 hours. The on-going reliance on a limited number of volunteers to fulfil highly responsible roles with associated statutory duties involving the care of residents did not effectively ensure management systems were adequate to the provision of a safe, appropriate, consistent and effectively monitored service.

Audits on medication, care plan reviews and falls assessments had been undertaken though the scope of some of these audits was quite limited and resulting action plans were not always reviewed. As a consequence minimal action had been taken on any related review of quality of care and the annual report in this respect had not been completed. Members of management spoken with during the inspection explained that the services of a quality management consultancy had been retained to address these issues and that a review of the service, particularly in relation to documentation around policies, procedures and audits was being undertaken.

Staff were aware of the requirements in relation to the regulations and a copy of the national standards was available and accessible at the centre. Members of staff spoken with were found to be committed to providing quality, person-centred care to their residents. Minutes of team meetings were available with the last recorded on 19 January 2015.

Judgment:
Non Compliant - Moderate

### 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 outlining the services and facilities of the centre was available to residents. The inspector reviewed a sample of resident contracts which included details of the overall fees to be paid and services to be provided in relation to care and welfare. The sample of contracts reviewed were dated and had been signed by the resident.

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 provider nominee also acted as person in charge in a full-time capacity and had held this position for more than twenty years. The person in charge demonstrated a knowledge of the legislation and statutory requirements appropriate to the role and was fully engaged with the governance, management and administration of the centre on a consistent basis. Both residents and staff recognised and could identify the person in charge as such. Appropriate deputising arrangements were also in place.

**Judgment:**
Compliant

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**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:**
A number of issues were identified in relation to the development and review of documentation and policies required in accordance with schedules 2, 3, 4 and 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013; these findings are detailed in the associated outcomes as summarised below.

Documentation in respect of schedule 2 was incomplete in some instances as detailed at
outcome 18 on staffing.

Documentation in respect of schedule 3 was not always complete as the directory of residents did not detail dates of admission or transfer and discharge in some instances.

Documentation in respect of schedule 4 also required development in relation to job summaries for staff and volunteers. Management explained this issue was being addressed as part of the review by the quality management consultancy that had been retained and detail around this finding is also recorded at outcome 18 on staffing.

Several policies or procedures in respect of schedule 5 were in incomplete or in draft form pending approval by the board of management including restraint, health and safety, medications management and complaints, again these findings are detailed at the relevant outcomes throughout this report.

Judgment:
Non Compliant - Moderate

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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 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:**
The person in charge understood the statutory requirements in relation to the timely notification of any instances of absence in relation to the post that exceed 28 days; and also the appropriate arrangements for management of the designated centre during such an absence. There had been no such period of absence by the person in charge since the last inspection.

**Judgment:**
Compliant

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**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:**
A policy was in place for the management of residents' personal property dated 9 March 2014 which also referenced finances and valuables. Policy was in keeping with the independent resident profile and residents retained responsibility for the management of their own finances. Where management acted as pension agents the relevant documentation was in place. In a sample of records reviewed inventories of personal belongings were appropriately documented and signed.

Staff spoken with understood what constituted abuse and, in the event of such an allegation or incident, were clear on the procedure for reporting the information. There was a policy on, and procedures in place for, the prevention, detection and response to abuse dated 20 April 2014 which was comprehensive and included directions where allegations were made against residents or visitors. The training matrix indicated training in this area was on-going with training last delivered on 14 August 2014. However, updated training in this respect was overdue for some members of staff. Action on this finding is recorded against outcome 18 on staffing.

Residents spoken with stated they felt safe in the centre and were clear on who was in charge and who they could go to should they have any concerns they wished to raise. There was no record of any allegations of abuse having been reported. A policy dated 3 April 2014 was in place on managing challenging behaviour though no policy was in place on the use of restraint. This action is being addressed as part of the overall review in relation to quality management systems previously referenced at outcome 5 on documentation. The person in charge explained that, in keeping with the low dependency profile of residents, the centre's policy was one of no restraint.

**Judgment:**
Compliant

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**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:**
A comprehensive risk management policy was in place covering the required areas in relation to unauthorised absence, assault, accidental injury, aggression, violence and self-harm. There was a draft health and safety statement in place which had not been
enacted and was still subject to board approval; related risk assessments had also not been completed. An emergency policy was in place dated 14 January 2015 and emergency and evacuation plans were on display.

An inventory of equipment, and its location, was in place and fire equipment had been serviced on 3 June 2014. Fire panels, emergency escape routes and emergency lighting were checked on a daily basis and logged accordingly. The fire alarm was tested weekly and serviced on a quarterly basis. Evacuation drills were documented for 6 December 2014. Corridors were kept clear and exits were unobstructed. There was written confirmation by a competent person of compliance with all the requirements of the statutory fire authority. Records were available to verify the annual servicing and maintenance of equipment. Staff spoken with understood what to do in the event of a fire or emergency though updated training had not been completed in all instances with fire training and manual handling outstanding in some cases. Action in this respect is recorded against outcome 18 on staffing.

The inspectors spoke with housekeeping staff and saw evidence of a regular cleaning routine and practices that protected against cross contamination, including the use of a colour coded cleaning system. An infection control policy was in place and effective infection control practices were observed with staff utilising personal protective equipment appropriately. Sanitising hand-gel was readily accessible and regular use by staff was evident. The premises overall was clean and adequately maintained.

There was a system for recording accidents and incidents though in some instances it was unclear how learning from such events was recorded or communicated to staff to ensure learning around the related risks was effectively implemented thereby minimising the possibility of recurrence.

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

**Findings:**
The centre had been the subject of a focused inspection on medication management in October 2014 and actions identified on that inspection related to records, training, policy development, supervision and assessment. The inspectors established that some corrective action had been taken in all these areas and in some instances was on-going.

A centre-specific policy on medication management was in place which covered the
required areas of prescribing, administration, storage and disposal. Records were made available to the inspector which confirmed that staff had read and understood the policy. The policy document required minor amendment in that it specifically referenced ‘tablets’ where a broader scope was necessary in relation to medications. Action in this respect is recorded against outcome 5 on documentation.

Training on medication management had been delivered in keeping with recommendations from the previous inspection. Records indicated training on medication management and administration and inhaled medication had all been delivered in the last quarter.

The centre engaged the services of the local community pharmacist which included the conduct of medication management audits. There was also evidence that residents were appropriately advised by the pharmacist in relation to their medications. Where residents were self-administering an appropriate tool for assessment and review had been introduced.

Medications were appropriately stored and the management of controlled drugs was safe and in accordance with current guidelines and legislation. The inspector observed a medication round and noted that practice was in keeping with guidance with administrations appropriately recorded. However, a review of records revealed an instance where a nebuliser had been prescribed twice daily when records indicated administration had occurred only once.

Although there was good evidence that appropriate corrective action had been taken in response to the last action plan, the findings of this inspection indicated that further supervision and assessment of the competency of staff in relation to the administration and recording of medication was needed. Action in respect of this finding is recorded against outcome 18 on staffing.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 10: Notification of Incidents</th>
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<tr>
<td>A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.</td>
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**Theme:**
Safe care and support

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

**Findings:**
At the time of inspection all notifications had been submitted in compliance with statutory regulations. A system for recording all incidents at the designated centre was in place and the person in charge was aware of the requirements to notify the Chief Inspector accordingly. Quarterly reports or nil returns were also provided to the
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
There were twenty two residents living in the centre on the day of inspection and all were assessed as being of low dependency. Inspectors found that the welfare and wellbeing of the residents was prioritised and suitable and sufficient care was provided. Staff and management at the centre demonstrated an active commitment to person-centred care. Care plans were individualised and staff spoken with had a well developed knowledge and understanding of the personal circumstances around individual residents. Residents spoken with felt very well cared for and supported in their choices; they were consulted with, and participated in, communication and decisions around healthy living choices including care plans, daily activities and personal preferences. Signed documentation on care plans was available in this regard.

A review of medical and care records of several residents demonstrated that there was timely access to medical care and the staff nurse confirmed that medication reviews were conducted quarterly by the GP with regular input also by the pharmacist. Residents were primarily under the care of the local GP practice although they could retain the services of their own GP also. An out-of-hours service was also available. Referral to and consultation with allied health services including mental health specialists and geriatricians was evident and the outcomes of these were documented. Chiropody, dentistry and ophthalmic care was facilitated.

A sample of care plans reviewed by the inspectors were seen to be person-centred with appropriate assessments using evidence based tools in use. Resident’s weights were monitored and changes responded to accordingly with input by a dietician where necessary in relation to both resident care and staff training. Care plans reflected residents’ social care, needs, preferences and strengths and were implemented in conjunction with the residents. There was evidence of reviews, including GP input, on at least a three monthly basis.
Residents’ social care needs and independence were well supported and they were encouraged to remain independent, make their own choices, remain active, and be involved in the local community. A day-care service operated from the centre once per week and residents participated in the activities provided including singing, memory games, mindfulness and music. The centre provided a meals-on-wheels service and the relatives of some residents availed of this service which also provided an further communication link to the community. Books and other materials were readily available. Local and national papers were provided daily. Residents had easy access to the local shop, post office and church. A number of residents attend the local community hall and go out with relatives or to visit their homes.

**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):**
No actions were required from the previous inspection.

**Findings:**
In general, the design and layout of the centre were suitable to meet the individual and collective needs of the resident profile in keeping with the centre’s statement of purpose. The building's original purpose had been as a boys' school. The current centre opened in 1974 as a voluntary service for the purpose of providing supported care for members of the local community. The premises itself, though dated, was well maintained and clean and effort had been taken to create a homely and inviting environment. The assessed needs of residents were relatively low with no reliance on assistive technologies, such as hoists for example, which reduced the impact on available space. The centre was located in the middle of town with good access to the amenities available such as the church, town hall, local stores and services. The building was constructed over two floors - access between floors was serviced by an elevator which was appropriately maintained and service documentation in this respect was available. There was a parking area to the front and side of the premises.

The premises comprised twenty, single bedded rooms and one twin, with wash-hand basins in all rooms. Two rooms were en-suite. Toilet and bathroom facilities were in keeping with regulatory requirements. However, there was no sluice room. Communal areas of the premises were well maintained with appropriate heating, lighting and ventilation throughout. Separate facilities were also available for staff. There was a
communal sitting room and dining room with a small oratory where mass was celebrated regularly. Residents' rooms were comfortable and provided the necessary space and storage for furniture and individual belongings. Facilities available for catering purposes were well maintained and equipped.

**Judgment:**
Non Compliant - Moderate

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

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

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

**Findings:**
A site specific complaints policy and procedure was in place dated 18 March 2014 which covered both written and verbal complaints. A summary of the complaints procedure was on display in the centre. Details of the nominated person responsible for dealing with complaints were provided along with a summary of the appeals process. Appropriate time frames were referenced with procedures for managing the complaint clearly outlined. Contact details were provided for an independent appeals officer with reference made to a process of referral to the Health and Safety Executive (HSE) also outlined, though no information was provided about access and appeal to the office of the ombudsman. Action on policy development is recorded against outcome 5 on documentation. The centre provided access to an independent advocacy officer who had received appropriate training from an external provider. Residents were aware of how to make a complaint though those spoken with indicated that any issues they might have were usually discussed and resolved with staff and no occasion had arisen to make a complaint. A review of the complaints log indicated that complaints were recorded and dealt with promptly though it was unclear from these records how any measures required for improvement as a result of a complaint were implemented.

**Judgment:**
Substantially 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:
The centre had been the subject of an inspection focused on end of life care in July 2014 when issues in relation to emergency first aid training had been identified. Members of staff spoken with were competent to deliver care and training in this area had been delivered to a number of staff in October 2014.

The person in charge understood the regulations in relation to the provision of end of life care and a policy was in place dated 29 January 2014. The policy was in keeping with the low dependency profile of residents and indicated that where the needs of a resident changed and end of life care provision became necessary, residents requiring such care would be referred for assessment and transferred to an appropriate service provider accordingly. A policy on residents’ personal property and a protocol for the return of personal possessions was also in place.

Religious and cultural practices were facilitated and residents had access to ministers from a range of religious denominations should such services be required. A review of documentation indicated that issues around spirituality and end of life were discussed with some residents though this information was not always incorporated into care plans. Action on this finding is recorded against outcome 5 on documentation.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
The centre had been the subject of an inspection focused on food and nutrition in July 2014 where the only action identified in an otherwise compliant outcome was in relation to a review of the menu by a nutritionist. That issue had since been addressed and staff spoken with explained that a training programme was also scheduled for February which would include direction on the use of recognised assessment tools for monitoring weight and nutrition.

Prague House Rest Home provides supportive care for those who have been assessed as
not requiring full time nursing care. As such the care provided was appropriate to the assessed needs of a resident profile with low dependency levels. Independent dining was encouraged and on the day of inspection there was no resident requiring assistance at mealtimes.

There was a centre specific policy on food and nutrition in place dated 15 January 2015. Of a sample of care plans reviewed by the inspectors all contained records of relevant monitoring with regard to nutrition and weight. The person in charge explained that access to allied healthcare professionals, such as a dietician or speech and language therapist, could be arranged via GP referral through community services where required.

Menus were varied with residents being offered choice at mealtimes. Members of staff spoken with demonstrated an understanding of the residents and their requirements and were seen to accommodate individual preferences where requested. Kitchen staff were appropriately trained and kitchen facilities were in keeping with the design and layout of the premises with adequate storage and effective systems around hygiene and infection control in place. The dining area was clean and bright with tables well laid for small groups. Facilities were also available for residents to have snacks and refreshments throughout the day. Residents spoken with were very satisfied with both the quality and quantities of food provided.

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:**
Residents spoken with reported positively on the experience of living at the centre stating that they were comfortable and felt safe and secure. The inspectors saw evidence that residents adopted a relatively independent daily routine and were fully supported in doing so by both staff and management. The mission statement of the centre referred to its aim as "creating a unique place where people feel cared for, valued and at home". The inspectors found that the intention of this statement was actively promoted by both staff and management in the day to day care at the centre. There was evidence that residents were consulted with and had an opportunity to participate in the organisation of the centre with minutes of residents' meetings available dated 12
November 2014. The inspectors also noted that where recommendations and suggestions were made these were seen to be enacted, such as the introduction of tea making facilities so that residents could be more independent in according hospitality to their visiting guests.

Facilities at the centre were adequate for recreation and occupation with a schedule of weekly activities available including input by an activities co-ordinator who also provided an advocacy service for the residents. All residents had access to recreational resources such as TV, radio and newspapers was also in evidence. The inspectors observed communication and interactions between residents and staff which were helpful and assistive whilst being courteous and respectful. Staff knew and understood the individual needs and preferences of residents and responded accordingly.

**Judgment:**
Compliant

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**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:**
Arrangements were in place for the regular laundering of linen and clothing and appropriate facilities were available for these purposes. Laundry staff spoken with understood the requirements in relation to segregation of garments and infection control procedures were in place. A formalised system of clothing identification was in place with individual garments labelled to ensure the safe return of items to residents.

A policy was in place in relation to residents’ personal property and possessions which also referenced valuables. The person in charge confirmed that residents had access to, and retained possession of, personal belongings and finances. The inspector noted that residents’ rooms were personalised with belongings and photographs and adequately furnished with clothing stored in individual wardrobes.

**Judgment:**
Compliant

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**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 centre had one qualified staff nurse available two mornings per week for a total of six hours. General staff supervision was adequate though the inspectors were of the view that, even in a low dependency resident profile, conditions could change rapidly and the nursing level did not sufficiently meet the requirements of supervision of staff in relation to medications management and administration, as well as the adequate assessment and review of a resident population of more than twenty. This opinion was further informed by the findings as detailed at outcome 9 on medication management.

Records indicated that staff training was kept under review though updated training in relation to elder abuse and fire prevention and precaution was overdue for several members of staff. Otherwise, training was in keeping with the profiled needs of residents. Staff spoken with were aware of the statutory requirements and standards in relation to the delivery of care and copies of relevant guidance were available at the centre.

Recruitment and vetting policies were in place dated 3 April 2014. The staff training and development policy had not been approved by the board of management and the person in charge explained this would action was pending and would be captured as part of the overall review being conducted in conjunction with an external consultancy firm. Procedures around recruitment were robust with verification of qualifications and references recorded in the sample of records reviewed, though in the case of one volunteer photographic identification was absent and only one reference had been obtained. Documentation in respect of schedule 4 also required development in relation to job summaries for staff and volunteers. Actions in respect of these findings are recorded against outcome 5 on documentation.

Judgment:
Non Compliant - Moderate
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:

Mairead Harrington
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>Support Care Facility Prague House</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000548</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>21/01/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>27/03/2015</td>
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</tbody>
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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 governance board were not implementing management systems that were sufficiently robust, or adequately resourced, to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
The Board of Management have now reviewed rotas to reduce the hours covered by the PIC and her deputy.

This will involve the recruitment of 2 additional members of staff to cover 21.5 hours between them and altering the hours of existing staff members to ensure there is not such a reliance on the PIC and her deputy. In turn, this will allow the PIC the time required to perform managerial and governance duties.

Interviews are due to commence on Friday 27 March 2015. The due date for commencement of this new rota is Monday 4 May 2015, providing all checks for new members of staff are in place at this time.

The Board of Management is in the process of setting up sub-committees to include:

1. Policies and Procedures
2. Health, Safety and Infection Control
3. Finance
4. Residents
5. Building Projects and Maintenance
6. Medication Management
7. Staff and Training
8. Fund Raising

Each sub-committee will be made up of at least one member of the Board of Management and one member of staff. The Quality Management System will be used by the sub-committees to review, audit and action findings, reporting back to management and the Board of Management. The data collected through the above method will be discussed and at monthly meetings or sooner if required with all staff. The implementation of the above will be the responsibility of Management and the Board of Management and is due to be fully operational by the end of May.

In the interim period reviews and audits will be conducted by the manager, nurse and the administrator, who is also a member of the Board of Management.

An annual report will be conducted by the Board of Management and a report of findings and future actions required, with the aim of developing and improving the quality of services provided.

The Quality Management System mentioned above has been developed by the Board of Management in consultation with a consultancy firm. These will be reviewed on an ongoing basis. Audits being prioritised to be conducted by 30 April 2015 include:

1. Medication Management
2. Statement of Purpose
3. Protection of Vulnerable Adults
4. Residents Needs
5. Staffing Levels and Qualifications

With the first feedback meeting taking place by 31 May 2015. Additional hours will be provided by the Board of Management to carry out and execute findings and actions of audits. A policy on Quality Management System is now operational.

**Proposed Timescale:** 31/05/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An annual review of service as set against the standards set by the Authority had not been completed.

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

**Please state the actions you have taken or are planning to take:**
A new Quality Management System is currently being implemented as outlined in the action above.

An annual review will now be conducted based on the data gained and produced through audits, risk registers and monthly meetings. This will be undertaken by the Board of Management to ensure the quality and safety of care provided to residents and the safety of staff, visitors and contractors as set out in Standard 30 and to further develop and improve the service provided.

**Proposed Timescale:** 31/05/2015

**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:**
Several policies or procedures in respect of schedule 5 were in incomplete or in draft form including
- restraint
- health and safety
- medications management
- complaints
- recruitment and vetting
**Action Required:**
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
All policies listed in Schedule 5 of the Health Act have now been approved by the BoM. These policies will come into effect on 31 April 2015. All staff will be given time to read and ask questions in relation to policy content and their implementation into practice. Training will be provided on same, which is scheduled to commence on 14 April 2015 and is due to be completed by 30 June 2015. Training on the policies will be carried out by the deputy manager.

Audits will be conducted in June on the effectiveness of the policies and a feedback meeting held with staff, management and members of the BoM. Follow on audits will be conducted through the Quality Management System and will be followed up in the process as outlined in Outcome 2 of this report.

The overall responsibility of implementation of Policies and associated training will rest with the deputy manager, overseen by the BoM.

**Proposed Timescale:** 30/06/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some entries in the Directory of Residents were incomplete in relation to dates of admission and transfer.

**Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
Directory now updated.

**Proposed Timescale:** 22/04/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
In relation to schedule 2 records for a volunteer were incomplete in relation to photographic identification and a second reference.

**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:**
Volunteer files are currently being updated to include all documents required under regulation.

**Proposed Timescale:** 22/04/2015

**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Ensure that records of relevant health planning, including considerations around end of life, are recorded in keeping with Schedule 3, paragraph 4 (b).

**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:**
The above documents will be maintained in line with regulations. This will be done through staff training and regular staff meetings outlined in outcome 2. In addition, audits will be conducted to ensure safety and quality of care and compliance with regulations. A full list of audits can be made available to the Authority. Audits and their findings will be monitored and reported on through the actions outlined in outcome 2.

Management and the BoM will have responsibility for ensuring implementation and review of audits.

**Proposed Timescale:** 31/05/2015

**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:**
Systems were not in place to identify hazards throughout the centre or assess the associated risks in order to implement protective and preventative measures.

**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:**
Health and Safety documents now approved by BoM. A system of recording and communicating accidents and incidents is now being implemented. Staff training will be provided to which all staff are obligated to attend. Immediate training includes:

1. Fire Training – 9 April 2015 (External trainer)
2. Medication Management 24 April 2015 (RGN)
3. Elder Abuse – through DVD, workbook and discussion, this training is due to be completed with all staff by 30 April 2015.
4. Manual Handling and People Moving – to be complete with all staff by 30 April 2015.

**Proposed Timescale:** 30/04/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Arrangements for the identification, recording, investigating and learning from serious incidents or adverse events required further development.

**Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
This will now be carried out through regular audits and collection of data. Sub-committees are being set up and will report back to the BoM on a bi-annual basis or sooner if required. The sub-committee will be made up of at least one board member and one member of staff, to which training will be provided.

**Proposed Timescale:** 31/05/2015

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Ensure that all records of administration of medications are in keeping with the directions of the prescriber.

**Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident.
concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

**Please state the actions you have taken or are planning to take:**
Training will be provided to staff on Medication Management including administration, storage and the importance of accurate record keeping by a RGN. Audits will be conducted by a RGN in relation to medication management, monitoring and reviews and will action and report back in the process outlined in outcome 2.

**Proposed Timescale:** 30/04/2015

**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:**
Provide premises which conform to the matters set out in Schedule 6, and in particular part 3 (e), having regard to the needs of the residents of the designated centre.

**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:**
Currently in process of obtaining quotes for the provisions of a sluice.

**Proposed Timescale:** 30/06/2015

**Outcome 13: Complaints procedures**

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Ensure that measures required for improvement in response to a complaint are put in place.

**Action Required:**
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**
All complaints will be dealt with in line with policy. Information within complaints will be used as a learning tool through training and through meetings with staff. This will include group or individual training and meetings as required, to ensure all complaints
are learnt from to improve the services provided.

In addition, data from complaints will be included in the annual review carried out by the BoM.

**Proposed Timescale:** 31/05/2015

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received updated training in relation to fire safety and elder abuse.

**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:**
Staff training on Fire Safety and Elder Abuse is now planned to which all staff members must attend.

**Proposed Timescale:** 22/04/2015

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The nursing staff rota required review to ensure appropriate levels of supervision over staff, including assessment of their competency to deliver care.

**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:**
Rotas have been reviewed by BoM to ensuring appropriate supervision at all times, taking into account the changeable needs of residents.

Staff rotas will be developed in conjunction with the changeable needs of residents. Resident’s assessment tools eg. Bartel Index and FRAT, will be looked at while developing rotas. Audits will be conducted to assess the competency of staff and on the assessment of residents needs to develop training action plans and ensure appropriate staffing at all times. These audits will be implemented as outlined in outcome 2.
In addition, management will supervise and perform appraisals to further establish where training and development is required.

**Proposed Timescale:** 31/05/2015