

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St Gabriel's Nursing Home
<b>Centre ID:</b>	OSV-0000174
<b>Centre address:</b>	Glenayle Road, Edenmore, Dublin 5.
<b>Telephone number:</b>	01 847 4339
<b>Email address:</b>	nursingstgabriels@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	SGNH Limited
<b>Provider Nominee:</b>	Helen Jones
<b>Lead inspector:</b>	Leone Ewings
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	65
<b>Number of vacancies on the date of inspection:</b>	1

## **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**

From:	To:
18 November 2014 09:30	18 November 2014 18:00
19 November 2014 09:30	19 November 2014 18:00

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

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

**Summary of findings from this inspection**

This was an announced inspection which took place over two days and was for the purpose of monitoring and informing an application to renew the registration of St. Gabriel's Nursing Home. The centre was purchased by this provider in 2012 as a designated centre for older persons and the provider has applied for registration for 66 places. This report sets out the findings of this registration inspection and areas for improvements.

The inspector found that overall the provider met many of 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 to a good standard. The management team had addressed the non-compliances further to the last inspection on 21 and 22 February 2013. Improvements had taken place relating to medication management, documentation, information about end of life care, health and social care needs, and staffing. Additional inspections had taken place during 2013 relating to monitoring, application to vary registration and a thematic inspection to monitor two specific outcomes; end of life and food and nutrition. Action plans further to these inspections were also followed up on during this 18 Outcome inspection.

The organisation consists of four directors', all except one are involved in the day to day management of the entity. During 2013 they appointed a person who acts as a provider nominee and also works as the person in charge. The inspector found that there was defined management team in place who worked to ensure that the governance structure in place. Changes had taken place to the provider nominee since the time of the initial registration process, and the Authority had been provided with full and complete information on the new provider nominee. She had been interviewed at the time of this change to ascertain fitness to undertake the role and responsibilities therein. The inspector acknowledged a substantial amount of preparation and ongoing work has taken place in preparation for renewal of registration.

Prior to this inspection the Authority were in receipt of a concern relating to staffing levels and also a concern about the suitability of the centre for respite care provision. The provider was found to have completed the investigation into the concern relating to a respite resident in a robust and full manner.

Four inspections has taken place during 2013 to monitor and review care provision at this centre; 7 March 2013, 24 July 2013, 19 August 2013 and a thematic inspection which took place on 19 November 2013. All of the action plans relating to non-compliances were followed up during this registration inspection in order to ascertain current compliance to 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 inspector found that overall the health needs of residents were met to a good standard. Residents had access to General Practitioner (GP) services, to a range of other health services and the nursing care provided was of an adequate standard. The quality of residents' lives was enhanced by the provision of a choice of interesting things for them to do during the day with activity and a variety of diversion therapies available. Improvements were required relating to provision of adequate dining space, ventilation and the communal day space provision on the first floor.

Residents had been consulted about the operation of the centre and there was an active residents' meeting. Residents and relatives knew the provider nominee on a first name basis and she operated an open door facility. The overall feedback from residents was one of satisfaction with the service and care provided on the day of the inspection. Some concerns were voiced to the inspector by a number of relatives relating to changes in the service provision and staffing of the centre. This aspect is

detailed further in the report under staffing and food and nutrition.

The provider and person in charge promoted the safety and quality of life of residents. A detailed review involving an external consultant had taken place and the provider nominee had a plan to address the recommendations made, and progress had been made in this regard. However, further resident centered quality of life feedback was necessary to fully comply with this outcome. The provider was found to be compliant with 10 of the 18 Outcomes and non-compliances in 8 Outcomes relate to action plans found at the end of this report.

A risk management process was in place for all areas of the centre. Staff had received training and were knowledgeable about the prevention of elder abuse, safeguarding and other relevant areas. Staff had a good knowledge of residents and their individual needs. Recruitment practices met the requirements of the Regulations, but staffing rosters were not fully maintained in line with legislative requirements.

Areas for improvement identified included the documentation of clinical care, completion of smoking risk assessments, documentation of chemical restraints in use. Although staffing levels were found to be generally adequate on the day of the inspection improvements were required relating to documentation of staffing roster, number of nursing staff employed and supervision of clinical care. However, the provider nominee agreed to review staffing provision based on feedback from respondents to the relative and resident questionnaires regarding concerns about the adequacy of supervision and staffing levels.

These areas for improvement are discussed further in the report and are included in the action plans 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 requested a revised statement of purpose as the document submitted with the application to renew registration was no longer in use and found that it had been recently reviewed and improved and was dated October 2014. Improvements included increase in the size of the written font and details on the range of resident dependency care needs provided for by the designated centre.

Overall the document met the requirements of Schedule 1 of the Regulations.

**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):**

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

**Findings:**

The roles and responsibilities were clearly defined and there was evidence of some audit and review of practice evident from this inspection and previous monitoring events. The person in charge had taken on the role of provider nominee since July 2013 and meets with a chief executive officer on a weekly basis. Relatives and residents confirmed that they could easily identify with the management team and both the provider nominee or her deputy were visible at the centre on a daily basis.

During the inspection the management team demonstrated effective communication and provision of information and records requested. However, some improvements were required relating to non-compliances not addressed or partially addressed further to inspections which took place during 2013. For example, provision of adequate dining space had not been evaluated further to inspection of 19 August 2013.

The provider and an external consultant had completed a review of quality and safety at the designated centre during October 2014, and were in the process of implementing a number of recommendations made. Improvements have commenced as a result of the learning from the external consultants feedback received prior to this inspection. However, the inspector found that there were no formal systems in place to review and monitor the quality of life of residents, other than through informal day to day observations. There was no evidence of detailed formal consultation with residents and their representatives and actively working on any feedback received from residents and relatives. For example, residents' access to communal day space has been affected by reduction of available space on the ground and first floors. The provider and management team were open to feedback given further to this monitoring event and demonstrated a pro-active approach.

Internal audit and review systems require further development, particularly relating to clinical audit, and key members of senior management team need to have training needs analysis with regard to management training requirements in order to sustain improvements.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector found that each resident had a detailed contract of care in place which

provided detail on the services to be provided and associated fees. The inspector reviewed a sample of the signed contracts of care and a copy of the current contract. Written contracts were agreed on admission. Additional fees for activity programme were clearly stated on the contract of care.

The resident's guide was detailed and had been recently updated, copies of which were seen to be available in residents accommodation and in the front reception area. Additionally a resident newsletter, notice boards and information leaflets were available for residents and relatives. Information about activity, meals and staff on duty was readily available.

**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 person in charge had not changed since the time of the last inspection during November 2013. Inspectors had determined the fitness and suitability of the person in charge further to her appointment in June 2012. She is a registered nurse and has demonstrated her knowledge of residents and in turn is well known to residents and relatives living at the centre. She is supported by two clinical nurse managers and the human resource manager.

The person in charge also works in the capacity as the provider nominee as outlined in Outcome 2, and reports to the CEO of the company who operates the centre.

**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):**

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

**Findings:**

Further to a review of a sample of operational policy and procedures at the designated centre, the provider had undertaken to review all policies and procedures further to the inspection which took place on 7 March 2013. The risk management policy was under review at this time, and was found to be still under review at the time of this inspection and had not been fully addressed by the provider. An electronic record keeping system was in place at the centre and staff easily retrieved most of the relevant information requested by the inspector at the time of the inspection.

Overall the records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. Some improvements had taken place since the time of the last inspection particularly relating to the accuracy of nursing and resident care records. However, further improvement was required following a review of a sample of the records;

- records of residents food and fluid intake were not fully maintained
- records made by care assistant staff were not always fully reviewed by staff nurses when informing the daily written reports.

All staff had received training and instruction on the use of the record keeping system and touch pads were in place for care staff to input care delivered were found on both floors. The inspector noted that the location of the touch pad computer screens needed review as they were located in resident communal space and restricted access to this space for residents as outlined in Outcome 12.

The inspector found that overall practices relating to restraint were implemented to a good standard and the risk register had been completed by the person in charge with regard to the use of physical restraint including alternatives to using bed rails and use of alarm mats. Some of the nursing and clinical records and were found to be completed to a good standard. However, improvements were required relating to maintaining consistent quality of each residents' records to reflect changing health and social care needs and the records relating to the use of medication management as outlined in Outcome 9 of this report.

The provider had ensured that 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 Centre for Older People) Regulations 2013. However, improvements were required relating to documentation of risk assessment to evidence any identified risks relating to resident who smoke at the centre, in line with the centres policy. One resident had a care plan in place but no written risk assessment had been completed to adequately monitor the risks associated with smoking in the centre. The person in charge confirmed this would be actioned on the day of the inspection. Improvements were also necessary with regard to completion of documentation which records of incidents and accidents inclusive of basic risk rating by staff that complete the record. Audit and review of accidents and incidents was reliant on information inputted into the electronic record keeping system by staff and an overall analysis of these inputs was not available to the inspector when requested.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The inspector formed the view that there were suitable arrangements in place for the management of the centre in the absence of the person in charge. The clinical nurse manager had the relevant skills, experience and references were confirmed during fit person interviews at the time of appointment. She was not on duty at the time of this inspection but a review of the management roster confirmed her working hours and she had previously been appointed as an acting person in charge. She was involved in the day to day supervision and review of practices at the centre.

At the time of the inspection the person in charge had not been absent for more than 28 days which required notification to the Authority.

**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):**

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

**Findings:**

The non-compliances relating to finance outlined in the inspection report dated 24 July 2013 were found to have been fully addressed by the provider. Records of finance and audit had been managed in an effective and transparent manner since this time. However, at the time of this inspection the provider informed the inspector that monies were no longer held for residents and no staff member acts as a pension agent for any resident on their behalf. The accounts held for the remaining three residents were reviewed and details and records of how funds had been dispersed were confirmed by a member of staff allocated this responsibility.

The inspector found that measures were in place to protect residents from being harmed or abused. All staff had received training on identifying and responding to allegations of elder abuse. A centre-specific policy was available which gave guidance to staff on the assessment, reporting and investigation of any allegation of abuse. The person in charge and staff spoken to displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures. Two notifications relating to adult safeguarding and allegations around staff practices at the centre had been notified to the Authority. The investigation report relating to both notifications and actions of the provider were requested and reviewed in line with the policy on adult safeguarding. The inspector found that policy had been followed and a robust investigation had taken place in both instances with regard to safeguarding all residents at the centre during the relevant fact finding and investigation. Both reports contained relevant recommendations appropriate to the findings, and plans were in place to facilitate additional training and supervision where required.

Residents spoken to and those who had completed the Authority's questionnaire commented and confirmed that they felt safe and secure in the centre. They attributed this to the fact that there was sufficient staff on duty to meet their needs and had access to call bells. However, some feedback received as outlined in Outcome 18 of this report expressed some concerns about staffing levels and supervision at other times including evenings, night time and at weekend, the provider was asked to review these concerns as communicated to the inspector in written questionnaires prior to this inspection.

There was a policy on and procedures for managing behaviours that challenge and a separate policy on the use of restraint which was closely aligned to the National policy. The person in charge had notified all incidents since the date of the last inspection, and these had been reviewed by the inspector and a satisfactory response and actions had been taken by the person in charge.

Staff had appropriate skills to respond to and manage behaviours associated with cognitive difficulties or decline. The inspector reviewed the records of residents and found that each episode of behaviour was documented and informed future care. Residents' assessments and care plans were in place and updated appropriately to guide care delivery. There was evidence that the GP and psychiatric services were involved in the care as required.

The use of restraint was largely in line with the national policy on restraint. For example, the beds used at the centre were all low profiling and alternatives such as the use of crash mats and bed alarms were used as alternatives. Residents who enjoyed walking and moving about could walk safely around the centre, and could use internal courtyards in dry weather. Overall the rationale for use of any form of restraint was documented, and the restraint register was reviewed by the person in charge. However, the inspector found that the documentation around the use of chemical restraint was not fully in line with the Standards and best practice this is discussed in Outcome 12 of this report. There was a system in place to monitor all residents using restraint and this was well supervised in practice.

All visitors were noted to have been greeted and signed in to a visitor's book at reception. The inspector observed the majority of staff delivering care in a way which safeguarded resident's dignity and also respected the individual rights of residents.

**Judgment:**  
Compliant

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**  
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**  
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**  
The inspector found that while there were systems in place in relation to promoting the health and safety of residents, staff and visitors, some improvements were required. The inspector found that the provider had addressed the requirements of a previous inspection on 7 March 2013 for staff to undertake fire training.

The inspector requested the revised risk management policies which were a non-compliance further to that inspection. The provider informed the inspector that the risk management document was still under review and the safety statement was also under final review. Provision of a risk management policy is actioned under Outcome 5 of this

report. Clinical audit and review of accidents, falls and incidents at the centre required improvement to inform learning and future practice.

Written confirmation received by the Authority on 25 September 2014 from a competent person that of all requirements of the statutory fire authority had been met, and this had been submitted to the Authority prior to the inspection.

Fire safety was found to be well managed in practice. Fire safety procedures were in place and staff demonstrated to the inspector a good working knowledge of what to do in an emergency. The inspector reviewed the emergency plan and found that it provided sufficient guidance to staff on the procedures to follow in the event of an emergency, and staff were very familiar with the contents of this plan.

There was evidence that all fire equipment including emergency lighting, fire extinguishers, fire alarm and fire doors were maintained and well serviced. The inspector viewed the fire training records and found that all staff had received up-to-date mandatory fire safety training and regular fire drills were carried out by staff at suitable intervals. The inspector also viewed the fire records which showed that fire equipment including the fire alarm had been regularly serviced. The inspector found that all internal fire exits were clear and unobstructed during the inspection. There was a system whereby a staff member checked fire exits daily and this was documented. The inspector noted that beds on the first floor had ski sheets in place, and that staff had been trained in evacuating procedures using large ski-sheet wall mounted emergency equipment from the first floor through stairwells and emergency exits.

All environmental issues which were identified on a daily basis were recorded for action by maintenance staff. The inspector was satisfied that most risks were identified, appropriately risk assessed and risks mitigated to prevent accident or incident. For example, the inspector found that the water at hand basins was temperature regulated and regular checks took place by external provider for Legionella. A generator was in place in the rear service courtyard for emergency use and this was maintained appropriately. Measures were in place to prevent accidents and facilitate residents' mobility, including non-slip floor covering in bathrooms and toilets.

However, on the day of the inspection the inspector noted some hazards in communal areas and cleaning rooms; the communal day room on the first floor was cluttered with furniture, footstools and tables at one end of the room, and the visitor's room had tea and coffee facilities in place but a large amount of visible electric wiring and plug boards sitting on the floor. Ventilation was poor in the upstairs cleaning room where mops and floor cleaning equipment was left to dry on both days, and this posed an infection prevention and control risk.

The health and safety statement had been reviewed during February 2013, but had not been updated this year. The provider had developed a risk register to identify and manage the risks in the centre. All staff had been trained in manual handling and appropriate practices were observed by the inspector, and sufficient assistive equipment was found to be available for use in a timely manner. Maintenance on hydraulic hoist equipment was up to date with six monthly reports. However, the hoist sling maintenance record was not fully completed, the provider informed the inspector that

the hoist slings would be inspected by the service provider and a record maintained for review. The smoking area was accessible by residents and used by a small number of residents, the inspector noted that external ventilation was in place and access to the garden area was through a door in this room also. Improvements were required relating to the records of the risk assessments for residents who smoked was outlined in Outcome 5 of this report.

The inspector found that overall there were measures in place to control and prevent infection. Staff were managing and controlling risks associated with infection and reporting and were aware of procedures to follow for managing any suspected outbreaks. Staff were knowledgeable in infection control and training had been provided, including hand hygiene. Staff had access to hand washing facilities, and supplies of gloves and disposable aprons and they were observed using the alcohol hand gels which were available discretely throughout the centre.

**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 inspector was satisfied that overall each resident was protected by the designated centre's policies and procedures for medication management. There was a medication policy which guided practice and administration practices were observed to be of a high standard. Improvements had taken place since the last inspection relating to prescription and administration charts, and the arrangements around crushing of medication. Nursing staff were familiar with the revised arrangements and appropriate storage requirements.

The inspector viewed completed prescription and administration records and saw that they were in line with best practice guidelines. Written evidence was available that three-monthly reviews were carried out. The pharmacist was also involved in medication safety and was available if required in the centre. Competency assessments were also completed with new nursing staff on induction. The inspector observed medication administration and found that medication was administered in line with the policy and best practice. However, psychotropic medications administered on an as required basis were not administered in line with best practice or alternatives tried prior to use at all times.

Medications that required strict control measures were carefully managed and kept in a secure cabinet in keeping with professional guidelines. Nurses kept a register of all controlled drugs. The inspector confirmed that the stock balance was checked and signed by two nurses at the change of each shift.

Detailed medication audits were completed by the clinical nurse manager to identify areas for improvement and there was documentary evidence to support this. Systems were in place to manage medication errors which were reviewed by the person in charge and systems were in place to minimise the risk of future incidents. There were appropriate procedures for the handling and disposal of unused and out of date medicines, and support from pharmacy provider. The staff nurses involved in the administration of medications at the time of the inspection had undertaken medication management training.

**Judgment:**

Non Compliant - Minor

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

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

Records of incidents occurring in the designated centre were maintained and where required, were notified to the Chief Inspector. A full review of all notifications took place by the inspector prior to this inspection and followed up on as part of the inspection process.

The person in charge was familiar with the reporting arrangements in line with recent legislative changes.

**Judgment:**

Compliant

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

The inspector was satisfied that resident's healthcare needs were largely met and facilitated by staff. Improvements relating to the non-compliance identified on the inspection of 19 August 2013 around arrangements to meet residents needs set out in a care plan had not been fully addressed. The inspector was not fully satisfied that the electronic record keeping system fully informed the requirement to maintain the records, daily communication and supervision at the designated centre could be improved. A new system of work allocation had been implemented further to the inspection findings but no audit or review of the revised arrangements had been put in place by the provider in her role as person in charge. For example, daily information staff hand over's took place morning and evenings, but a midday handover was also scheduled but did not always take place according to staff at the centre.

The feedback relating to activity provision available at the centre was found to be good, the garden was accessible to residents. A daily mass service which took place each day at 12 in the chapel. Respondents to the questionnaires named enjoyable activity such as quizzes, outings, using the garden for activity and music at the centre. Two activities co-ordinators worked at the centre, and activity such as crafts, exercises, gardening and pet therapy were available. Posters informing residents and relatives about daily activity was evident, and a plan for a Christmas shopping trip were being arranged and advertised at the time of the inspection.

Residents had access to general practitioner (GP) services and a full range of other services was available on referral including speech and language therapy (SALT) and dietetic services. Chiropody, dental and optical services were also provided. Psychiatry for older persons community services had also been consulted for a number of residents and given recommendations for managing behaviours which challenge and management of mental health difficulties experienced by some residents. A physiotherapist and occupational therapist was available and reviewed residents on referral. The inspector reviewed residents' records and found that residents had been referred to these services and records and results of appointments were written up in the residents' medical notes. For example, residents who were assessed for specialised seating were assessed and reviewed for provision of this seating and wheelchairs.

The inspector reviewed a sample of residents' files and noted that medical reports were maintained in a hard copy file separately to the nursing and care notes on the electronic record keeping system. The provider had implemented an electronic record keeping system and information was readily available and accessible. Nursing assessments, care planning and additional clinical risk assessments were carried out for residents. Residents and/or relatives confirmed they were involved in the development of their

care plans and they discussed this with the inspector. Overall care plans reviewed by the inspector contained the required information to guide the care for residents, and were updated to reflect the residents changing care needs. Some of the written care plans were not fully person centred and did not accurately reflect the care requirements identified and observed on inspection. For example, the nutritional care plans in place were not adequate to fully meet individual requirements of a small number of residents. In addition, care plans were not fully implemented relating to provision of required fluid intake, or evaluated on a frequent enough basis by nursing staff.

Whilst the evidence was that care delivery was in the most part largely in line with evidence based practice for most residents. However, improvements were required in how clinical, nursing and social care information informed the daily care provided for each resident, and the reviews required to maintain a consistent level of quality care provision. The inspector read the care plans of residents who had fallen and saw that risk assessments were undertaken and a care plan was devised. Preventative measures undertaken included the use of chair alarms and hip protectors. However, some residents did not have up to date moving and handling written assessments in place to inform practice.

There was an adequate policy in place on falls prevention to inform and guide staff. Neurological observations were completed when residents sustained an unwitnessed fall. Improvements were required to records of clinical incidents which were found to be completed by the attending nurse. Whilst medical and nursing follow up took place, a full review of care plans was not evidenced following all incidents and accidents in order to prevent recurrence.

Audit and review did not take place on a consistent or basis. The provider had identified this as an issue during the recent quality and safety review and was in the process of actioning improvements in this area. Records or care staff inputs on the touch screen were not found to be fully reviewed by nursing staff in a meaningful way to ensure best outcomes for the resident record sample reviewed (Outcome 5). The need for increased supervision of residents in communal areas was observed by the inspector. Resident safety and supervision was not being fully maintained in line with the identified clinical risk assessment used for falls prevention and completed by nursing staff. This aspect of service provision had also been clearly identified by a number of relatives through their written questionnaire responses prior to this inspection, this was clearly communicated at the feedback for action under Outcome 18 of this inspection report.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

The premises were improved following an application to vary registration in 2013 and resident accommodation for 66 people and residents are accommodated over two floors. Access to the building is controlled and all visitors are asked to sign in and undertake hand hygiene. A review by the inspector took place of the plans submitted and confirmed on inspection. The design and layout of the premises is largely suitable for the stated purpose as outlined in the Statement of Purpose. There were adequate toilet, shower and bathroom facilities for resident use. One resident passenger lift and three stairwells are in place.

The ground floor has a reception area, activities room, administrative offices, large chapel, a visitor's room, person in charge's office and a hairdressing salon. Food from the main kitchen on the ground floor is transported to the communal day space of each floor. Two bedrooms on the first floor are subject to a restrictive condition owing to steps required to access these rooms and only residents with low dependency may occupy these rooms. The provider was found to be fully complying with the conditions of registration in this regard.

The bedrooms provided are as follows and were reviewed during the application to vary process and met with the legislative requirements and continue to meet the stated purpose as outlined in the statement of purpose:

**Ground Floor**

- 20 single bedrooms with en-suite toilet and wash hand basin
- 4 single bedrooms with full en-suite facilities
- 2 twin bedrooms with full en-suite facilities

**First Floor**

- 30 single bedrooms with en-suite toilet and wash hand basin
- 4 single bedrooms with full en-suite facilities
- 2 twin bedrooms with full en-suite facilities

All the centres' facilities were found to be available to each resident on all to those on both floors. The environment had not been specially adapted or re-designed to provide care for residents with dementia or cognitive difficulties. The inspector recommends that consideration is given to the environment requirements as outlined in the Standards inclusive need to provision of appropriate signage as discussed with the provider.

The inspector noted that increased resident numbers from 53 to 66 had put additional requirements in place for dining and day space. The requirement to address the non-

compliance for additional dining space had been part identified previously at the inspection of 19 August 2013. The provider had completed a review and added a new dining space adjacent to the sun room. However, further to the additional residents and observation of practice on inspection the current arrangements remained inadequate to meet all residents needs in a comfortable and practical way. A number of residents ate their meals in the day space of the ground and first floor, and a smaller number took their meals in their own bedrooms. The option of attending the dining room or eating in a dining room which was appropriately furnished for dining was not available for all residents. Some residents who ate in the day space also had to wait for assistance and did not have the same opportunities for independent dining as was offered to other residents attending the dining room.

The inspector noted that there was a maintenance programme in place. There was adequate lighting, and heating in place throughout the building. Ventilation was observed to be inadequate in the cleaner's room on the first floor, and also in the respite en-suite room on the first floor.

The laundry facilities were reviewed and found to be adequate and were located in the ground floor bedroom area and well equipped with appropriate washing and drying machines and facilities to iron linens and clothing. Hot water was thermostatically controlled to wash hand basins and shower/bath facilities, and the hairdressing room.

Storage facilities were adequate and corridors were wide and had handrails in place. All residents had access to a outdoor secure courtyard and open walkways around the building. Appropriate seating was in place for leisure and garden activities. An indoor smoking space had been designated for residents use. A visitor's room near reception was a private space where visitors could meet with residents.

The kitchen was an adequate size in relation to numbers of residents at the centre. The inspector reviewed the last environmental health inspection report dated April 2014 where a detailed inspection had taken place and substantial compliance found.

**Judgment:**

Non Compliant - Major

***Outcome 13: Complaints procedures***

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

Complaints were found to be well managed, and the provider was the nominated complaints officer. The complaint's policy was in place and the inspector noted that it met the requirements of the Regulations. The complaints procedure was on display in reception at the centre. Relatives and residents who spoke with the inspector knew the procedure if they wished to make a complaint. Residents and relatives were aware of the name of provider and spoke about how she was so approachable.

The Authority had received unsolicited information relating to the care and welfare of a resident and the issues relating to a respite admission during 2013 which was reviewed as an overall part of this monitoring event. This complaint was found to have been investigated and responded to by the provider who had responded in writing to the complainant. The inspector was satisfied that this complaint had been fully documented and investigated in line with the policy. Complaints and feedback from residents were viewed positively by the provider and the person in charge. Feedback came from individuals and through the resident's meetings facilitated by the group advocate.

There were no written complaints since the previous inspection from any long term resident. The provider and her deputy had dealt with issues raised verbally and a record had been maintained in the resident's record.

**Judgment:**

Compliant

***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 provider had implemented an informative information booklet for resident's representatives and a copy was given to the inspector.

All lines of enquiry were not reviewed at the time of this inspection as a detailed thematic inspection had taken place during November 2013. The centre had close links with palliative care community organisation and pastoral care support in place at this time.

**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):**

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

**Findings:**

The provider had partially addressed the non-compliance relating to food and nutrition and how the intake was not always recorded in a timely manner. The provider had responded and stated that "all staff nurses have been reminded to ensure that fluid intake is correctly documented for those residents that require fluid intake monitoring". The inspector was not satisfied that safe systems were in place to appropriately supervise staff caring for some residents to record the actual fluid intake and fully evaluate and monitor care safely. Therefore this non-compliance had only been partially addressed.

Overall food and drinks were provided in quantities adequate for residents needs, and available on a regular and as required basis. Menus were reviewed and food options gave choice and variety, and were based on feedback from residents and inputs and review from the dietician. The review by the external consultant during October 2014 had observed a mealtime and a number of recommendations around the mealtime experience and supervision had been made. The provider told the inspector they would act on this and a plan was in place.

The main dining room on the ground floor was attractively decorated, and well ventilated, with space to move wheelchairs and mobility aids between the tables. A smaller dining space beside the sun room was also utilised. However, the arrangements were not adequate to accommodate the additional residents who had been admitted since the time of the variation to register in line with the non-compliance noted by the inspectors at this time as outlined in Outcome 12.

The inspector observed mealtimes at the centre and found that food was attractively presented and very much a social occasion. Residents were offered a choice of food at each meal time and individual preferences were readily accommodated. The care staff were allocated to the dining room and monitored the meal times closely. Residents' who required their food to be modified, for example pureed, were served this food in individual portions and had the same choice of food at the main meal which was presently separately on the plate. Drinks were provided during the day and with meals. Portion sizes were appropriate and second helpings were offered. All residents expressed satisfaction with their meals to the inspector on the day of the inspection.

However, the availability of a drinks round to residents unable to independently access

their own mid morning was not seen. The person in charge confirmed individual requests for drinks were accommodated. The inspector was concerned that some residents were observed to have dry mouths and the records of fluid intake were not sufficient to meet their daily needs in some cases.

The inspector spent time in the dining room and visited residents who also chose to eat the main meal in their bedrooms and found that the dining experience was dignified, pleasant and relaxed for the residents. The inspector observed staff seated beside residents assisting them with a meal and assisting one resident at a time with their meal. The meal time provided opportunity for social interaction between staff, residents and relatives. A small group of resident ate their meals in the communal day space on both floors. However, there were no appropriate table and dining space allocated on the first floor and all residents who ate in these areas could only receive assistance on a limited basis as staff were moving residents to and from the main dining areas at this time. Some relatives visited to assist with mealtimes and were welcomed and assisted to do so.

Relevant information pertinent to the meal time was in place and was reviewed by the chef and the provider. The inspector met with the chef who demonstrated an in depth knowledge of residents dietary needs, likes and dislikes and this was well documented. Snacks were provided at any time as requested, a variety of snacks, such as yoghurt, scones and toast were available.

The inspector found that weight records showed that residents' weights were checked monthly or more regularly if required. Nutrition assessments were used to identify residents at risk and were also repeated on a regular basis. Records also showed that some residents had been referred for and received a recent dietetic review. However, some plans had not been updated to reflect changes in residents care particularly relating to the residents who require fluid intake monitoring. Medication records showed that supplements were prescribed by a doctor and administered appropriately. However staff provided fortified meals as a first choice as individually required.

The inspector recommends that alternatives to clothes protectors in use were investigated and offered as an alternative at the centre, and consideration be given to reviewing supervision arrangements in the dining and day rooms where meals were taken by nursing staff.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

The inspector was satisfied that overall staff treated residents with respect, with regard to each individuals' privacy and dignity and that strong emphasis was placed on these values by the provider.

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. The inspector observed staff interacting with residents in a friendly and courteous manner. There was an open visiting policy and contact with family members was encouraged and facilitated.

Residents' meetings took place within the centre, the last minutes reviewed by the inspector indicated it had been chaired by the group advocate. Many residents told the inspector they had opportunities to discuss issues as they arose with the person in charge, provider or any staff member. All staff were seen to interact well with residents during the inspection. The person in charge told the inspector that any issues raised by residents for example, in relation to food were addressed at local level and at the resident forum.

Residents had access to an independent advocate and advocacy services if required.

Relatives said if they were kept up to date with any changes in health or social care, and communication was good in this regard.

The inspector found that most residents said they had flexibility in their daily routines, for example, residents could decide whether to participate in activities available to them. They chose when to go to bed and the time they got up. One relative was concerned that changes in care plan such as having an additional shower day were accommodated, but had been difficult to achieve owing to staffing difficulties.

The inspector noted that televisions had been provided in residents' bedrooms. Residents had access to daily newspapers, and residents could access computer and internet.

Residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences every day at the centre with the programme on view. Improvements had taken place in this area. There were two activity staff employed in the centre and a large designated activity space. A schedule of activities was available each day and the inspector noted that various activities were being provided throughout the centre. The hairdresser visited regularly and was working on the day of the inspection. Residents commented they enjoyed their activities such as crafts, art and gardening. There was evidence that residents engaged in activities such as music, SONAS (a therapeutic communication programme specifically for residents with

dementia), exercises, quizzes and hand massage.

Social care assessments were in place in respect of all residents and residents, which included individual likes and dislikes and each resident had a care plan to guide the social care services delivered.

**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 could have their laundry attended to within the centre, and the laundry operated seven days a week. Residents and relatives expressed satisfaction and were complimentary about the laundry service provided. All laundry services were provided on site. Adequate storage space was provided and there were procedures in place for the management of laundry that required additional infection control procedures. Residents admitted under the Nursing Homes Support Scheme had laundry services included in the overall fee and this was outlined in the contract of care, and resident's guide.

Residents had access to a private locked space in their bedroom if they wished to store their belongings. There was a policy in place of residents' property in line with the Regulations and a list of residents' property was maintained by staff.

**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):**

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

**Findings:**

On the day of inspection the inspector found that the current staffing levels, qualifications and skill mix were appropriate for the assessed needs of residents. The inspector acknowledges that a number of residents and questionnaires received prior to this inspection indicated that residents and relatives were happy with the staff and the care provided. However, a number of the residents, relatives and staff agreed that there were times when there were inadequate levels of staff on duty and needs were not always met in a timely manner.

Further to a review of staffing the number of qualified staff nurses was down due to anticipated leave and replacement was through use of agency and relief staff and this was used to cover other unanticipated leave and night duty. The numbers of whole time equivalent nursing staff was not reflected in the staffing roster owing to long term leave. The human resources manager confirmed that the permanent staff would be returning to their posts early in 2015, cover for this leave was not found to be adequate or optimal and increased clinical supervision and review of care was necessary. The staff roster was also found to be incomplete and details of staff names, hours and designation were not fully maintained in line with legislative requirements.

The inspector acknowledges that increased staffing was put in place further to the increased registered numbers following an application to vary numbers of residents. The provider had provided additional staff and a review of cover provided by the clinical nurse manager had taken place and now a clinical nurse manager or senior nurse was on duty from 8am - 8pm every day. Staffing levels had been closely reviewed by the provider and an external consultant just prior to this inspection. Staffing levels were not clearly stated in the statement of purpose and function during the day, or at night. Staff and relatives reported to the inspector that the care available in the two sitting rooms on first and ground floor was not always adequate with 'lapses' in available care. Although improvements had taken place since the last inspection further to an action plan, and the review of staffing levels reported on was found to not to be optimal as no feedback from residents / residents' representative or observation of care (other than one mealtime) had taken place at this time, although a validated tool had been used to inform the judgement.

Feedback from relatives spoken to by the inspector expressed satisfaction with the existing facilities and staffing levels. However, the respondents from some questionnaires expressed concerns in relation to availability of staff during some of day and night. The inspector discussed her concerns with the provider and informed the management team of the relevant feedback by the inspector. The management team undertook to review current staffing provision to meet resident needs.

The inspector found that there was a very committed and caring staff team. The person in charge and provider placed strong emphasis on training and continuous professional development for staff. Staff told inspectors that they felt well supported by the person in charge, management team and the provider. A clinical nurse manager was individually responsible for supervising care for each of the floors. In practice one staff nurse and a team of care assistants provided direct care and each floor had a defined allocation sheet for duties and care provision.

Resident dependency was assessed using a dependency scale on the electronic record keeping system. The inspector found that the nature of resident dependency had further increased since the time of the last inspection in that 66 residents were now accommodated and this included three temporary respite beds. Further improvements and staffing review was required to review the staffing levels further to the feedback from residents and relatives.

The inspector found that there were procedures in place for supervision of residents in the communal areas, and additional staffing could not always be sourced internally with a clear system in place that staff were familiar with. Care staff have received training in use of the touch screen electronic record keeping system, and demonstrated competency in this area.

Staffing and recruitment were closely reviewed and a sample of staff files was examined on this inspection. The inspector noted that all relevant documents were present, and vetting procedures were up to date. Administrative supports were in place to assist the provider and human resources manager.

Staff told the inspector they had received a broad range of training which included food hygiene, dementia care, end of life care, infection control, dysphagia, and the use of the malnutrition universal screening tool.

A training plan for 2014/20155 was in place for staff. The majority of the health care assistants employed had completed Further Education and Training Awards Council (FETAC) level five or above. A system of staff appraisal had not been established by the provider at this time. Training was provided for staff in areas such as medication management, fire safety and managing challenging behaviours.

The inspector reviewed all files and found that nursing staff had up to date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for 2014.

Staff told the inspector there were open informal and formal communication within the centre. The inspector found that there were formal arrangements to discuss issues and residents needs as they arose, at nurses meetings and staff meetings held regularly.

While nurses provided supervision of staff and residents on a daily basis and reported on the work of the care staff. The provider had not implemented training with nursing staff relating to their responsibilities for supervision and delegation of work to care assistants and allocation of workload.

**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:***

Leone Ewings  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	St Gabriel's Nursing Home
<b>Centre ID:</b>	OSV-0000174
<b>Date of inspection:</b>	18/11/2014
<b>Date of response:</b>	26/01/2015

### Requirements

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

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

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

Audit and review practices relating to clinical outcomes were not consistently monitored by nursing and management staff.

#### 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

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

monitored.

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

Since the inspection, we have developed an annual audit programme and associated documentation to:

Collect data on clinical outcomes on a monthly basis.

Conduct analysis of specific outcomes, both on a scheduled basis and as triggered by trending.

Conduct detailed audits of priority areas, both on a scheduled basis or as triggered by trending.

The clinical governance committee will review and trend the data on clinical outcomes at each meeting and identify any actions required.

Mentoring for the senior management team has been arranged so as to enable the clinical governance team undertake the activities outlined above.

Proposed Timescale: 31st January 2015 and ongoing.

**Proposed Timescale:** 31/01/2015

**Theme:**

Governance, Leadership and Management

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

The review of quality and safety did not adequately provide for the views and in consultation with residents and their representatives.

**Action Required:**

Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

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

We will develop a questionnaire to carry out a satisfaction survey with residents and relatives. The questionnaire will be based on the 18 outcomes so as to link with and be included in the annual review of quality of care and services.

We will carry out a quality of life survey with resident's using a recognised tool for measuring quality of life with residents who have the capacity to be involved and a recognised tool for measuring quality of life in residents with cognitive impairment and dementia.

**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:**

The risk management policy had not been fully updated since the time of the last inspection.

**Action Required:**

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

The risk management policy has been revised and updated and a copy of same is being forwarded to HIQA.

**Proposed Timescale:** 26/01/2015

**Theme:**

Governance, Leadership and Management

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

The risk assessment documentation was not found to be completed for any resident who smoked at the centre with regard to risks outlined in care plans and observed at the centre.

**Action Required:**

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

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

Risk assessments for residents who smoke have been completed.

**Proposed Timescale:** 26/01/2015

**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:**

The centre does not have robust systems in place to monitor falls, incidents and accidents in order to learn from serious incidents or adverse events involving residents.

**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:**

The risk management policy had been updated to provide detailed guidance on identifying, recording, investigation and learning from incidents, including serious incidents.

As outlined under outcome 2, clinical outcomes will be monitored, trended and analysed by the clinical governance committee.

Investigation of individual incidents will include identification of learning and how the learning will be disseminated.

Incidents, accidents and adverse outcomes will be reviewed at each clinical governance meeting to identify trends and take remedial action as required.

Risk management training will be provided to staff, to include the management of incidents/accidents protocols that have been added to the policy.

Proposed Timescale: Risk management policy completed. Clinical governance system will commence before the 31st January 2015. Risk management training will be provided to staff by the 28th February 2015.

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

**Theme:**

Safe care and support

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

Physical hazards and trip risks were identified during the inspection in communal day space and in the visitor's room which had not been identified and risks mitigated by the provider.

**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:**

All hazards and trips risks will be identified by the end of January and remedial action will be taken by the end of February.

We will implement a robust system of conducting environmental safety checks on a scheduled basis, so as to identify hazards and risks, complete risk assessments, and

take remedial action to eliminate or mitigate the risks identified.

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

**Theme:**

Safe care and support

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

Arrangements to dry mops and cleaning materials in a room which was inadequately ventilated posed an infection prevention and control risk.

**Action Required:**

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

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

A ventilation fan has been ordered and will be fitted.

**Proposed Timescale:** 31/01/2015

**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:**

As required use of psychotropic medication was not administered in line with best practice or alternatives tried prior to use at all times.

**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 has been arranged for staff nurses on the appropriate use of psychotropic medications.

Medication management audits will include monitoring of the administration of psychotropic medications.

The use of psychotropic medicines is included in our monthly data collection that will be reviewed at each clinical governance meeting.

Proposed Timescale: Training and review of use of psychotropic medicines will commence prior to 31st January 2015.

**Proposed Timescale:** 31/01/2015

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

**Theme:**

Effective care and support

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

Nutritional care plans require review to ensure they reflect the actual care required in a person centred way, and reflect individual needs.

**Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

In order to address all of the findings of the inspection for Outcome 8, we will take the following actions:

1. A standard protocol will be developed for nursing staff on completion of daily records. This will include:
  - The need to update all relevant assessment and care planning documentation for any resident whose care and / or condition has changed during their shift.
  - The need to review all records completed by healthcare assistants for an individual resident prior to completing that resident's daily records and to follow up on any area of concern noted in these records

Timescale 31/01/2015.

2. Handover practice will be standardised to include the completion of a handover form that the nurse will complete at the end of her shift. This form will require the nurse to:

- Enter the names of any resident whose condition has changed during the shift.
- Record any incident, event that occurred during her shift and the name(s) of the resident involved.

3. The nurse will sign to the effect that all records have been updated as required for these residents.

4. The CNM on duty will check this list at the beginning of her shift and will be responsible for liaising with the nurse to ensure that any follow up actions required for these residents has been completed and that residents' records have been updated as required.

Timescale 28th February 2015.

5. To improve supervision of resident care, a system of intentional scheduled 'care and comfort' rounds will be introduced for residents. The frequency of these rounds for some residents will be increased if additional supervision and monitoring of their condition and needs is required. Individual nursing and care staff will be allocated to

each of the rounds and records in place to monitor residents, including fluid balance charts will be checked as part of these rounds.

Timescale 28th February 2015.

6. The CNM on duty will complete a round of all residents during her shift and again check that records have been completed as required.

Timescale 28th February 2015

7. Nursing and care staff will attend a training day on all of the above. This training will include a session on 'recognising and responding to deterioration' in a resident's condition, which will emphasise the need for care staff to report changes to nursing staff on a timely basis during their shift.

Timescale 28th February 2015.

8. We will also review the rostering and allocation of staff throughout the 24 hour shift and ensure that residents are supervised according to their needs.

Timescale 28th February 2015.

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

**Theme:**

Effective care and support

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

Planned care was not always fully implemented, or evaluated in line with assessment and written care plan in place, particularly relating to identified requirement for fluid intake.

**Action Required:**

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

In order to address all of the findings of the inspection for Outcome 8, we will take the following actions:

1. A standard protocol will be developed for nursing staff on completion of daily records. This will include:

- The need to update all relevant assessment and care planning documentation for any resident whose care and / or condition has changed during their shift.
- The need to review all records completed by healthcare assistants for an individual resident prior to completing that resident's daily records and to follow up on any area of concern noted in these records

Timescale 31/01/2015.

2. Handover practice will be standardised to include the completion of a handover form that the nurse will complete at the end of her shift. This form will require the nurse to:

- Enter the names of any resident whose condition has changed during the shift.
- Record any incident, event that occurred during her shift and the name(s) of the resident involved.

3. The nurse will sign to the effect that all records have been updated as required for these residents.

4. The CNM on duty will check this list at the beginning of her shift and will be responsible for liaising with the nurse to ensure that any follow up actions required for these residents has been completed and that residents' records have been updated as required.

Timescale 28th February 2015.

5. To improve supervision of resident care, a system of intentional scheduled 'care and comfort' rounds will be introduced for residents. The frequency of these rounds for some residents will be increased if additional supervision and monitoring of their condition and needs is required. Individual nursing and care staff will be allocated to each of the rounds and records in place to monitor residents, including fluid balance charts will be checked as part of these rounds.

Timescale 28th February 2015.

6. The CNM on duty will complete a round of all residents during her shift and again check that records have been completed as required.

Timescale 28th February 2015

7. Nursing and care staff will attend a training day on all of the above. This training will include a session on 'recognising and responding to deterioration' in a resident's condition, which will emphasise the need for care staff to report changes to nursing staff on a timely basis during their shift.

Timescale 28th February 2015.

8. We will also review the rostering and allocation of staff throughout the 24 hour shift and ensure that residents are supervised according to their needs.

Timescale 28th February 2015.

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

**Theme:**

Effective care and support

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

Records or care staff inputs on the touch screen were not found to be reviewed by nursing staff in a consistently robust and meaningful way to ensure best outcomes for the resident record sample reviewed.

**Action Required:**

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

In order to address all of the findings of the inspection for Outcome 8, we will take the following actions:

1. A standard protocol will be developed for nursing staff on completion of daily records. This will include:

- The need to update all relevant assessment and care planning documentation for any resident whose care and / or condition has changed during their shift.
- The need to review all records completed by healthcare assistants for an individual resident prior to completing that resident's daily records and to follow up on any area of

concern noted in these records

Timescale 31/01/2015.

2. Handover practice will be standardised to include the completion of a handover form that the nurse will complete at the end of her shift. This form will require the nurse to:

- Enter the names of any resident whose condition has changed during the shift.
- Record any incident, event that occurred during her shift and the name(s) of the resident involved.

3. The nurse will sign to the effect that all records have been updated as required for these residents.

4. The CNM on duty will check this list at the beginning of her shift and will be responsible for liaising with the nurse to ensure that any follow up actions required for these residents has been completed and that residents' records have been updated as required.

Timescale 28th February 2015.

5. To improve supervision of resident care, a system of intentional scheduled 'care and comfort' rounds will be introduced for residents. The frequency of these rounds for some residents will be increased if additional supervision and monitoring of their condition and needs is required. Individual nursing and care staff will be allocated to each of the rounds and records in place to monitor residents, including fluid balance charts will be checked as part of these rounds.

Timescale 28th February 2015.

6. The CNM on duty will complete a round of all residents during her shift and again check that records have been completed as required.

Timescale 28th February 2015

7. Nursing and care staff will attend a training day on all of the above. This training will include a session on 'recognising and responding to deterioration' in a resident's condition, which will emphasise the need for care staff to report changes to nursing staff on a timely basis during their shift.

Timescale 28th February 2015.

8. We will also review the rostering and allocation of staff throughout the 24 hour shift and ensure that residents are supervised according to their needs.

Timescale 28th February 2015.

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

**Theme:**

Effective care and support

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

The records of food and fluid intake recorded for each resident were not subject to the level of clinical review necessary as required by nursing staff supervising residents' changing care needs to reflect the current status of the resident at the centre.

**Action Required:**

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with

professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

In order to address all of the findings of the inspection for Outcome 8, we will take the following actions:

1. A standard protocol will be developed for nursing staff on completion of daily records. This will include:

- The need to update all relevant assessment and care planning documentation for any resident whose care and / or condition has changed during their shift.
- The need to review all records completed by healthcare assistants for an individual resident prior to completing that resident's daily records and to follow up on any area of concern noted in these records

Timescale 31/01/2015.

2. Handover practice will be standardised to include the completion of a handover form that the nurse will complete at the end of her shift. This form will require the nurse to:

- Enter the names of any resident whose condition has changed during the shift.
- Record any incident, event that occurred during her shift and the name(s) of the resident involved.

3. The nurse will sign to the effect that all records have been updated as required for these residents.

4. The CNM on duty will check this list at the beginning of her shift and will be responsible for liaising with the nurse to ensure that any follow up actions required for these residents has been completed and that residents' records have been updated as required.

Timescale 28th February 2015.

5. To improve supervision of resident care, a system of intentional scheduled 'care and comfort' rounds will be introduced for residents. The frequency of these rounds for some residents will be increased if additional supervision and monitoring of their condition and needs is required. Individual nursing and care staff will be allocated to each of the rounds and records in place to monitor residents, including fluid balance charts will be checked as part of these rounds.

Timescale 28th February 2015.

6. The CNM on duty will complete a round of all residents during her shift and again check that records have been completed as required.

Timescale 28th February 2015

7. Nursing and care staff will attend a training day on all of the above. This training will include a session on 'recognising and responding to deterioration' in a resident's condition, which will emphasise the need for care staff to report changes to nursing staff on a timely basis during their shift.

Timescale 28th February 2015.

8. We will also review the rostering and allocation of staff throughout the 24 hour shift and ensure that residents are supervised according to their needs.

Timescale 28th February 2015.

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

**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:**

Dining space was found to be inadequate to meet all residents needs.

**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:**

A review of dining space will be undertaken to ensure each resident is facilitated to enjoy a dining experience of their choice.

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

**Theme:**

Effective care and support

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

Ventilation in Room 35 respite room en-suite and in the cleaner's room on the first floor was not found to be adequate.

**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:**

Ventilation fans for both these areas have been ordered.

**Proposed Timescale:** 31/01/2015

**Theme:**

Effective care and support

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

Communal day space on first and ground floor was not found to be adequate or organised in a manner which met the assessed needs of each resident line line with their requirements for space.

**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:**

A review of the communal day spaces will be undertaken and new items of furniture will be ordered. The Provider will further review these areas to ensure the reorganised areas meet residents' needs in line with their requirement for space.

**Proposed Timescale:** 14/03/2015

**Outcome 15: Food and Nutrition**

**Theme:**

Person-centred care and support

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

Drinks were not routinely offered mid morning to all residents at the designated centre, and drinks were not readily visible in communal day spaces.

**Action Required:**

Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

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

As part of the system of 'care and comfort' rounds residents will be offered drinks at each check.

Signage will be placed on water dispensers and fridge for those residents who can independently fetch drinks.

Jugs of water and drinks will be placed in each communal areas and the staff member allocated to each of these areas will offer drinks to residents on a frequent basis.

The presence of the jugs and 'coloured' drinks will be used to provide prompts to residents to ask for drinks.

**Proposed Timescale:** 31/01/2015

**Theme:**

Person-centred care and support

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

There were times when residents had to wait a prolonged time to get the individual assistance with planned care around eating and drinking at mealtimes outside the main dining room environment.

**Action Required:**

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff

are available to assist residents at meals and when other refreshments are served.

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

A review of the dining times will be included in the dining space review to ensure all residents are provided with a pleasant dining experience.

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

**Theme:**

Person-centred care and support

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

A small number of residents with specific fluid intake requirements did not have adequate fluids offered or documented in line with individual care requirements.

**Action Required:**

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

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

This action will be addressed as outlined in the previous section and in the action plan identified under Outcome 8.

**Proposed Timescale:** 31/01/2015

**Outcome 18: Suitable Staffing**

**Theme:**

Workforce

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

Nursing staff employed on the roster were not fully in line with the numbers submitted as part of the registration process and stated in the statement of purpose for the centre.

**Action Required:**

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

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

The permanent Nursing staff numbers have been temporarily depleted due to maternity leave. We have therefore replaced these two staff members with agency Nurses.

The agency has consistently provided Staff Nurses who have become very familiar with residents' needs and to ensure residents are provided with consistency of care. The provider has documentation from the Agency concerned which confirms that they are fully compliant with legislative requirements. The computer rostering system is being amended to allow it record the name of each agency staff rostered. One permanent Staff Nurse will return to work on 9th January 2015 and the second Staff Nurse by the end of February 2015.

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

**Theme:**  
Workforce

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

Staff supervision procedures are not fully established in order to safely meet the ongoing and changing needs of each resident.

**Action Required:**

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

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

As outlined previously, a review of staff rostering and allocation over the 24 hour period will be undertaken.

Additionally, it is intended that the introduction of intentional rounding by nurses and clinical nurse managers will strengthen and improve supervision of staff and resident care.

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

**Theme:**  
Workforce

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

Mealtimes in the resident day space were not adequately supervised by nursing staff.

**Action Required:**

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

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

Nursing staff no longer administer medications during mealtimes and there is one Staff Nurse now present in areas where residents are dining.

<b>Proposed Timescale:</b> 26/01/2015