<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Cahermoyle House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000412</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Ardagh, Limerick.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>069 76 105</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@cahermoylehouse.com">info@cahermoylehouse.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Candor Holdings Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Martin Lynch</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Julie Hennessy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Louisa Power</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>34</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>8</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 06 July 2015 09:00
To: 06 July 2015 16:30

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

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

Summary of findings from this inspection

This report sets out the findings of an inspection of Cahermoyle House Nursing Home, which was announced four days prior to the inspection. This was a follow-up inspection that was carried out to monitor the compliance with the Regulations due to the high level of non-compliance identified in the previous inspection in February 2015. This inspection will also serve to inform a decision in relation to an application by the provider to renew the registration of the centre.

Inspectors met with residents, the provider, the person in charge and members of the staff team. Inspectors observed practices, the physical environment and reviewed documentation such as policies, procedures, risk assessments, residents' files and training records.

Since the previous inspection, a suitably qualified and experienced person in charge...
had been recruited and commenced in the centre three weeks prior to this inspection. While the person in charge was only in the centre a very short period of time, he had demonstrated an understanding of the actions required to address the areas that required improvement.

Overall, inspectors found that the provider demonstrated willingness to bring the centre into compliance with the Regulations. At the previous inspection, inspectors identified non-compliances in 14 out of 18 outcomes and five out of 18 outcomes were at the level of major non-compliance. On this inspection, it was found that the specific failings at the level of major non-compliance from the previous inspection relating to fire safety, manual handling equipment, complaints, notifications, verification of staff references, and deputising arrangements in the absence of the person in charge and the premises had been reduced or addressed in full. However, further improvement was required to improve the quality and safety of care delivered in the centre. Four major non-compliances were identified during this inspection relating to medication management, restrictive practices, contracts of care and hazards in the centre that could put residents at risk.

Other non-compliances identified related to staff training, health safety and risk management, care planning, meeting residents’ communication needs and monitoring of the service. Required actions should be read in conjunction with findings in the body of the report and the action plan at the end of the report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
At the previous inspection, the Statement of Purpose did not contain all of the information required by Schedule 1 of the Regulations.

Since the previous inspection, the Statement of Purpose had been revised and submitted to the Authority and now contained all of the information required by Schedule 1.

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:
At the previous inspection it was found that an effective management structure was not in place in the designated centre to ensure that the service provided was safe,
consistent and effectively monitored. The post of the person in charge was vacant and the deputising arrangements in place were insufficient. A system was not in place that ensured that an annual review of the quality and safety of care delivered to residents in the designated centre took place. Finally, the monitoring of the service required improvement. Improvements were required to ensure that audits contributed to the delivery of safe, quality care services in a meaningful way.

Since the previous inspection, steps had been taken to make the management structure more effective. A new person in charge had commenced in the centre and an assistant director of nursing (ADoN) had recently been recruited. Reporting structures had been clarified. Inspectors spoke with staff who outlined specific changes that supported them in their work such as improved communication and clarification of staff reporting structures. Staff also said that they anticipated that the commencement of a new ADoN and the creation of ‘senior carer’ positions would be very beneficial.

At the time of inspection, the gaps in relation to auditing were still evident. For example and as will also be mentioned in Outcome 9: Medication Management; medicines management audits had been completed but were limited in scope and did not cover all aspects of the medicines management cycle, as necessary to ensure that there was a comprehensive system in place to review and monitor safe medicines management practices. Audits reviewed did not identify some of the pertinent deficiencies identified in this inspection. Inspectors saw that action plans were not always generated following audits to ensure that actions identified were completed in a timely fashion. The provider told inspectors that an auditing system was being developed by an external consultancy to assist the provider with meeting his obligations in terms of monitoring the service and to ensure that audits contributed to the delivery of safe, quality care services in a meaningful way.

Work had commenced in relation to the completion of an annual review of the service and an inspector reviewed a report of such a review. Further improvement was required to ensure that the annual review comprises a review of the quality and safety of care delivered to residents in the centre in accordance with relevant standards set by the Authority; is prepared in consultation with residents and their families and; that a copy of the review is also made available to residents.

**Judgment:**
Non Compliant - Moderate

**Outcome 03: Information for residents**
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
At the previous inspection it was found that the residents’ guide did not include all of the information required under the Regulations. Also, the contracts of care did not include the details of the fees to be charged for services provided in the centre. At this inspection, it was found that both actions had yet to be implemented in full.

The residents’ guide had been revised since the previous inspection and was dated 4 July 2015. It now included most, but not all, of the information required by the Regulations. The terms and conditions relating to residence in the centre were not included.

At this inspection, it was found that the provider had commenced issuing updated and amended contracts of care to all residents. However, the person in charge had completed an audit of contracts of care and identified further gaps. For example, six residents had no contracts and this finding is at the level of major non-compliance. Other gaps included that rates were not specified in 13 contracts and the signing of a large number of contracts (21) had not been witnessed. This was in the process of being addressed and the provider had made contact with an appropriate person to witness the signing of contracts for residents who did not have a representative.

**Judgment:**
Non Compliant - Major

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**Outcome 04: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
At the previous inspection, the person in charge had recently resigned her post and the post was vacant at the time of inspection. This action had now been satisfactorily addressed.

A suitably qualified and experienced person in charge had been recruited and commenced in the centre three weeks prior to this inspection. The person in charge is a registered psychiatric nurse with prior experience as a director of nursing and in providing care to older persons. The person in charge demonstrated understanding of his responsibilities under the Regulations. While the person in charge was only in the
centre a very short period of time, he had demonstrated an understanding of the actions required to bring the centre into compliance. The person in charge had identified and prioritised key areas to be addressed including in relation to the management of behaviour that challenges, restrictive practices, care planning and wound care.

**Judgment:**
Compliant

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**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
It was identified during the previous inspection that not all policies required under Schedule 5 were in place, had not been developed in line with evidence-based practice and/or had not been implemented. Inspectors saw that this action had been completed since the previous inspection and all policies required had been reviewed and updated and were now in place.

It had been previously identified that two written references were not available for all staff. An inspector reviewed a sample of staff files and found that two references were available in each of the files reviewed. However, a vetting disclosure was not on file for one staff member. This was brought to the attention of the provider and person in charge who stated that the previous disclosure had been mislaid and a new application for vetting had been completed but had not yet been processed.

It had been previously identified that the directory of residents was not complete. The directory of residents was viewed by inspectors who saw that all information required was included.

It had been previously identified that property lists had not been completed or kept up to date for residents. Inspectors saw, based on a sample reviewed, that property/furniture lists had been completed for residents but had not been reviewed and updated.
As outlined in outcome 9, medicines administration records were not always accurately maintained. For example, an inspector noted that a record for the administration of an antibiotic noted that the medicine was administered at dinnertime and teatime. However, the time of administration was not recorded in line with ‘Recording Clinical Practice Guidance to Nurses and Midwives’ guidance issued by An Bord Altranais agus Cnáimhseachais.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 06: Absence of the Person in charge</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>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.</em></td>
</tr>
</tbody>
</table>

**Theme:**
Governance, Leadership and Management

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

**Findings:**
At the previous inspection, the Authority had not been notified in writing of the absence of the person in charge or the arrangements in place for that absence, as required. Since then, all of the required notifications had been made to the Authority and the action had been satisfactorily addressed.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 07: Safeguarding and Safety</strong></th>
</tr>
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<tbody>
<tr>
<td><em>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.</em></td>
</tr>
</tbody>
</table>

**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:**
It was identified during the previous inspection that practices in relation to restraint and positive behaviour support were not in line with national policy as published by the Department of Health. Inspectors saw that this action had not been completed.

At this inspection, a centre-specific policy in relation to the support of residents with behaviours that challenge was made available to the inspectors and had been reviewed since the previous inspection. Staff reported and inspectors saw that residents had access to consultant psychiatric services.

An inspector found that 'single separation' was in use for one resident. While this had been approved by an appropriately qualified professional (a senior clinical psychologist), the application, documentation and oversight of this practice was not acceptable. The inspector reviewed a letter from the psychologist that said that clear 'parameters' had been provided to staff in relation to the use of single separation and gave examples of such parameters, e.g. that the resident should not be left alone during such times. However, an inspector was unable to ascertain from staff or the resident's file whether or what other parameters had been provided to staff. In addition, the example of one parameter provided in the letter, which was that the resident should not be left alone during single-separation, was not being followed as staff said that while the resident was regularly checked, the resident was left alone during such times. The inspector spoke with one staff nurse who said that this practice had been used three of four times since December 2014. However, logs were not maintained of any such occasions, as required. As a result, monitoring and review of the practice, including it's effectiveness, did not take place. This was discussed with the person in charge, who as previously mentioned had only commenced in the centre three weeks prior to inspection and was not aware of this practice. The person in charge said that he would immediately complete a full review of the practice.

Inspectors identified that not all staff had completed training to support residents with behaviours that challenge and staff with whom inspectors spoke lacked knowledge in relation to the de-escalation and evidence-based management of challenging behaviour. However, the person in charge had scheduled training for staff to address this gap.

Positive behaviour support plans had not been developed for residents to give clear guidance to staff in the proactive management of behaviours that challenge including the identification of triggers and underlying causes. Clear and appropriate person-centred strategies were not outlined to ensure that a positive approach was used to support residents in a consistent and coherent manner.

Based on a documentation reviewed, inspectors noted that restrictive practices were not always used in accordance with "Towards a Restraint Free Environment in Nursing Homes", a policy document published by the Department of Health. Care plans in relation to restrictive procedures did not outline sufficient detail to guide staff in consistent and decision making in relation to the use of restrictive procedures. Where restrictive practices were used, a clear assessment had not always been completed prior to the use of restrictive practices; documentation reviewed by inspectors did not outline sufficient detail in relation to every episode where restrictive practices were used. Alternative strategies trialled were not always outlined. Therefore, it was not evidenced that all episodes of challenging behaviour were managed in a manner that was least
restrictive in all cases, if alternative strategies had been ineffective and the use of the restrictive procedure had been reviewed after use. The person in charge had also identified this gap in a recent review since he commenced working in the centre.

Where bedrails were in use, inspectors saw that a risk balance tool was available to be used prior to the use of bedrails which would guide consistent and effective decision making. However, inspectors saw that many of the documents had not been completed in full. Therefore, the rationale for the use of bedrails and their suitability for individual residents were not clearly assessed. Multi-disciplinary input had not been sought in the decision-making process.

**Judgment:**
Non Compliant - Major

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

**Theme:**
Safe care and support

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

**Findings:**
At the previous inspection, improvements were required to the risk management policy and the measures in place to identify hazards, assess risks and monitor and review measures in place to control risks. In addition, the provider had not ensured that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. For example, some parts of the centre required attention, there were gaps in training, there was no system in place to monitor and audit staff hand hygiene practices and some practices observed in relation to the management of dirty linen were not acceptable. Finally, the provider had failed to ensure that all staff of the designated centre received suitable training in fire prevention and emergency procedures, including evacuation procedures and with particular regard to the building layout and escape routes.

Since the previous inspection, one action had been implemented in full and two actions had been partially implemented. Further gaps relating to fire safety and the management of risks were identified at this inspection.

The risk management policy had been reviewed and revised and now included the areas of risk specified in the Regulations. The risk register had been updated and included risks in the centre such as medication errors, use of restraint, unexplained absence of a resident and slips, trips and falls. While the controls outlined to manage such risks were detailed and specific, the risk register required further improvement. For example, the
majority of risks were rated at the level of ‘extreme’ or ‘high’ and there was no residual risk rating following implementation of controls in place. It was not clear how the effectiveness of such controls was being monitored. There was no risk assessment for the absence of stair-gates at the top of stairs leading to the upstairs bedrooms. The infection control risk assessment did not include hand hygiene training as a control. There was no risk assessment for the risk posed by a threshold step in each en-suite shower in the ‘West Wing’. Manual handling risk assessments were inadequate as they were not sufficiently detailed to guide staff.

In addition, the inspectors found that the level of risk to residents posed by the absence of stair-gates at the top of stairs leading to the upstairs bedrooms and the on-going presence of threshold steps in the en-suite showers of the ‘West Wing’ was not acceptable and these significant hazards needed to be addressed. The person in charge had identified a resident at risk of falling down the stairs. This was discussed with the provider and person in charge over the course of the inspection, who agreed that these hazards would be addressed without delay. Such hazards were found to be at the level of major non-compliance.

With respect to the prevention and control of healthcare associated infections, improvements had been made since the previous inspection. The centre was visibly superficially clean. Colour-coded cleaning systems were in place. Cleaning schedules were in use and were maintained and included regular ‘deep clean’. The management of linen had been reviewed. The person in charge had completed a review of the centre and this included some aspects of infection control, including wound management and the cleaning of medical equipment. While the centre had an infection control policy in place, staff required training in relation to how to implement the procedures, including training in hand hygiene and how to prevent and manage healthcare associated infections. Hand hygiene and infection control audits were not currently in place. The infection control risk assessment required review. The person in charge said that a new nurse facilitator was due to commence in the centre shortly and this will allow them to develop this area further. In addition, there was already one staff nurse who had received training in relation to the management of catheters and other nurses were scheduled to complete this training.

Since the previous inspection, all staff had received suitable training in fire prevention and emergency procedures. However, the fire extinguishers were overdue the annual service since 14/4/2015 (13 weeks prior to the inspection). In addition in the ‘West Wing’, the fire doors in the toilet and bathroom had been negated as holes were observed in those doors.

Judgment:
Non Compliant - Major

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
## Safe care and support

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

### Findings:
The centre-specific policies in relation to medicines management were made available to inspectors which had been reviewed in March 2015. The policies were comprehensive and evidence based. The policy was made available to staff who demonstrated adequate knowledge of this document.

Medicines for residents were supplied by a local community pharmacy. There was evidence that the pharmacist was facilitated to meet his/her obligations to residents.

Medicines requiring refrigeration were stored appropriately. However, inspectors noted that the refrigerator was not locked and stored in a clinical room accessible to non-nursing staff. As outlined in Outcome 11: Health and Social Care Needs, the temperature of the refrigerator was not monitored on a regular basis. All other medicines were stored securely in a locked cupboard or trolley. Handling and storage of controlled drugs was safe and in accordance with current guidelines and legislation.

Staff with whom inspectors spoke demonstrated knowledge and understanding of principles in relation to safe medication management practices. An inspector observed the administration of medicines and saw that this was evidenced in practice. The practice of transcription was in accordance with professional guidance issued by An Bord Altranais agus Cnáimhseachais.

An inspector observed that monitored dose systems were used by staff to administer medications to residents. However, the references and resources available were not complete to allow those administering medicines to confirm and identify individual medicines in the monitored dose system. Therefore, staff could not ensure that the medicines within the compliance aid were administered in line with the prescription.

An inspector reviewed a sample of prescription and medication administration records. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. However, as outlined in Outcome 5: Documentation, an accurate medicines administration record was not always maintained.

During the inspection, an inspector identified a medication error where a resident could have potentially not received medicines as prescribed. This was brought to the attention of the staff on duty immediately and the person in charge stated that an investigation would be carried out.

Inspectors saw and staff confirmed that residents did not require medicines to be administered in a modified form such as crushing and no resident was self-administering their own medicines at the time of inspection.
Inspectors noted that medicines management audits had been completed but were limited in scope and did not cover all aspects of the medicines management cycle to ensure that there was a comprehensive system in place to review and monitor safe medicines management practices; this was previously addressed in Outcome 2: Governance and Management.

Staff outlined the manner in which medicines which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. Competency assessments for medicines administration had been completed for the majority of nurses. Training in medicines management had not yet been completed; this is covered in Outcome 18: Suitable Staffing.

**Judgment:**
Non Compliant - Major

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

**Findings:**
At the previous inspection it was found that all notifications had not been submitted as required. Since that inspection, all notifications have been submitted to the Authority as required.

**Judgment:**
Compliant

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

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

**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
At the previous inspection, it was found that a comprehensive assessment of residents’ social care needs had not been completed and that care planning required further improvement. This action had not been adequately addressed. Inspectors reviewed a sample of care plans for pain management, behaviour that challenges, meeting residents’ social care needs, communication, wound care and diabetes. Overall, care planning was inconsistent with care plans in transition between two different systems. As a result, it was not always clear what care plan was in use to direct care for each resident. In addition, while some care plans directed the care to be delivered to the resident, others did not. The person in charge had also identified this as an area for development in a recent review.

The second action from the previous inspection related to a resident who had not received a prescribed nutritional supplement for a number of days, with no comment included as to why it had not been administered. This specific action had been adequately addressed.

At the previous inspection, it was found that where it had been identified that a resident required supports that the designated centre was unable to provide, steps had been taken to that time to find a more suitable placement for that resident. However, it was found at this inspection that this issue had not progressed further since the previous inspection. As a result, the centre did not meet the assessed needs of all residents. This finding at the previous inspection was now increased to the level of moderate non-compliance.

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:
At the previous inspection, inspectors found that the premises did not fully meet the requirements under Schedule 6 of the Regulations. Some areas of the premises required attention; not all equipment for use by residents was in good working order. Some of the stair gates were difficult to secure. On the first floor of the 'West Wing', there were no grab-rails next to toilets in any of the ensuite bathrooms. In the unoccupied double room, there were no grab rails in the shower or toilet. In addition, the shower trays in every shower on this floor had a threshold step that residents had to step over to access the shower. On the first floor of the 'East Wing', there was one toilet for 12 residents and there was no bath or shower on this floor. Also on the first floor of the 'East Wing', inspectors observed that the bedrooms were confined in terms of space. In the communal area downstairs, there were an insufficient number of toilets for use by residents. Screening in the two double bedrooms was not adequate. In addition, the design and layout of the centre was not in line with the statement of purpose and the floor plans did not adequately describe the location of toilets, bathrooms and showers.

At this inspection, it was found that while a number of areas had been addressed, one action had yet to be fully implemented.

Hoists and slings were observed to be in good condition and the person in charge had ordered additional equipment. The areas of the premises that required attention had been addressed and planned maintenance was in progress.

In the ‘West Wing’, while grab-rails had been fitted next to the toilets in the ensuite bathrooms, the unoccupied double room still had no grab rails in the shower. As identified during the previous inspection, the shower trays in every shower on this floor had a threshold step that residents had to step over to access the shower. In both East and West Wings, the stair-gates had been removed since the previous inspection but there were now no stair-gates in place. The person in charge had already identified this as a required action. This was discussed at the close of inspection and the provider and person in charge said that they would address this without delay. Some of these items are also addressed in the context of risk under Outcome 7: Health Safety and Risk Management.

On the first floor of the 'East Wing', a new accessible toilet and shower had been installed since the previous inspection. Screening in the two double bedrooms in the ‘East Wing’ was still inadequate. The screens were plastic and too short in length from ceiling to floor. The layout of the bed in one double bedroom was not acceptable as the curtain rail was situated at a level directly above the middle of the bed. The resident’s locker could not be placed next to the bed as there was a cupboard behind the headboard, meaning that the locker would effectively be in the middle of the room if placed alongside the bed.

In the communal area downstairs, there were an insufficient number of toilets for use by residents. The provider had identified a solution to this issue that would result in the provision of two new toilets downstairs close to the kitchen/activities/prayer room. In the interim, an additional visitor’s toilet would be made available for residents to access.

Since the previous inspection, the design and layout of the centre was now in line with
the statement of purpose and revised accurate floor plans had been submitted to the Authority.

As identified on the previous inspection, the bedrooms on the first floor of the 'East Wing' were confined in terms of space. The provider agreed to ensure that such bedrooms would not be used by any resident who required assistive or adaptive mobility aids or appliances. On the day of inspection, no resident requiring such aids or appliances were in these bedrooms. Also on this inspection, it was identified that in the (vacant) double bedroom in the West Wing, exiting in the event of an emergency necessitated climbing three steps, traversing a room and descending four steps to exit via the dedicated fire exit. As a result, no resident residing in this room would be able to have any degree of mobility or cognitive impairment and would need to be fully independent. The provider agreed to include a self-imposed restriction in the Statement of Purpose to address these two issues.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
At the previous inspection, the complaints log was not made available during the inspection for review. At this inspection, the complaints log was made available for review and was being maintained. In addition since the previous inspection, the complaints policy had been updated and a ‘complaints’ box had been commenced and was prominently displayed in the centre.

Further review was required to the complaints policy and procedure. Clarity was required to the complaints procedure to ensure that it clearly outlined how complaints are managed in the centre and the independent appeals person could not be considered fully independent. The provider and person in charge agreed to seek a more suitable independent appeals person and update the complaints policy accordingly.

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

Findings:
At the previous inspection, formal consultation processes were not in place in the centre. In addition, residents did not have access to independent advocacy services. While steps had been taken to address both actions, they had yet to be fully implemented. An additional action in relation to meeting the communication needs of residents was identified at this inspection.

Since the previous inspection, plans had been put in place to commence residents meetings and posters relating to same were visible in the centre. Residents’ meetings had yet to commence and consideration was required in relation to how residents’ who chose not to participate in such meetings would be consulted with or represented.

Links had been developed with an advocacy service for older people and the person in charge said that he had also contacted a peer advocacy service. Signage was visible in the centre in relation to advocacy. However, further work was required to identify residents who may require an advocate.

The screening in two double bedrooms was still not adequate as screens were of a plastic material and were not sufficiently long from ceiling to floor. One screen did not fully close on one side. This was previously mentioned in the context of the premises under Outcome 12.

At this inspection, it was also found that where communication needs had been identified, they had not always been fully met. While a resident with communication needs had been reviewed by a speech and language therapist (SALT), it was not demonstrated that recommendations had been implemented in full. An inspector reviewed a SALT report that referred to a communication passport or some means of alternative communication for a resident. However, a staff nurse said that there was no specific communication aides used for that resident. The resident’s communication care plan was not detailed and did not reflect the recommendations of the SALT.

Judgment:
Non Compliant - Moderate
**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):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
At the previous inspection, it was found that some small items of clothing were not labelled.

At this inspection, it was found that a new system for labelling clothes and personal belongings had been introduced. The inspectors visited the laundrette and found clear arrangements in place to prevent residents’ belonging going missing.

**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:**
It was identified during the inspection in February 2015 that not all staff had were up to date with mandatory training including challenging behaviour, abuse prevention and fire safety. This action had not been completed in full. All staff had completed fire safety
training. However, gaps were still evident in relation to the completion of training in challenging behaviour and abuse prevention. Four staff members had not completed manual handling training.

A training needs analysis was made available to inspectors which highlighted other areas where staff required training and development such as medicines management and end of life care. This training was planned but had not yet been provided.

**Judgment:**
Non Compliant - Moderate

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**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:**

Julie Hennessy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Cahermoyle House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000412</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>06/07/2015</td>
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<tr>
<td>Date of response:</td>
<td>25/08/2015</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Audits were limited in scope, did not identify some of the pertinent deficiencies and action plans were not always generated to ensure that actions were completed in a timely fashion.

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

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

**Please state the actions you have taken or are planning to take:**
A new and more robust audit system has been formulated and is in the process of being implemented. First audits from the new audit package will be conducted within the next two weeks from the date of writing and a resulting action plan will be put in place which will have clearly defined time scales.

**Proposed Timescale:** 30/09/2015  
**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The annual review was not prepared in consultation with residents and their families.

**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:**
The annual review process has been re-initiated by the new management team. The process involves the residents and their immediate family members and was discussed at first resident forum which met in the library on Thursday 13th August and thereafter will meet on a two monthly basis. Quarterly reviews, which will be quantitative and qualitative in nature, will be carried out on 29/10/2015 and 28/01/2016.


**Proposed Timescale:** 28/01/2016  
**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
A copy of the annual review was not available to residents.

**Action Required:**  
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

**Please state the actions you have taken or are planning to take:**
The last annual review has now been made available to the residents.

**Proposed Timescale:** 23/08/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The annual review required development to ensure that such a review determined whether the quality and safety of care delivered to residents was in accordance with relevant standards set by the Authority.

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

**Please state the actions you have taken or are planning to take:**
The annual review process has been further developed by the new management team. The annual review will be compiled utilising ongoing quality control audits to ensure adherence to the standards set down by the Authority. Quarterly reviews, which will be quantitative and qualitative in nature, will be carried out on 29/10/2015 and 28/01/2016

**Proposed Timescale:** For Quarterly review – 29/10/2015. For Annual Review – 28/01/2016

**Proposed Timescale:** 28/01/2016

**Outcome 03: Information for residents**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The residents’ guide did not include the terms and conditions relating to residence in the centre.

**Action Required:**
Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

**Please state the actions you have taken or are planning to take:**
The resident guide is now inclusive of the terms and conditions relating to the residents within the centre.

**Proposed Timescale:** 07/08/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Six residents did not have a written contract.

**Action Required:**
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

**Please state the actions you have taken or are planning to take:**
New contracts of care have been updated which will outline terms of residency within the Home and will be agreed with the six residents by 30th September 2015

**Proposed Timescale:** 30/09/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All contracts of care did not include details of the fees to be charged for services provided in the designated centre.

**Action Required:**
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

**Please state the actions you have taken or are planning to take:**
New Contracts of care have been updated and reviewed which will outline the terms of residency within the home.
A completion process has been initiated and is expected to be finalised by 30th September 2015.

**Proposed Timescale:** 30/09/2015

**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:
Improvements were required to some documentation to meet the requirements of Schedule 2, 3 and 4 of the Regulations. For example, a Garda vetting disclosure was not on file for one staff member, medicines administration records were not always accurately maintained and property/furniture lists had not been reviewed and updated.

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

**Please state the actions you have taken or are planning to take:**
Garda vetting forms are in situ for staff members. When new staff are recruited, copies of the Garda applications are placed within their files.

As part of the new robust auditing routine staff files are regularly and randomly monitored.

**Proposed Timescale:** 07/08/2015

**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Training had not been completed for all staff in relation to the response and management of behaviour that is challenging and some staff were unable to articulate adequate knowledge in this area.

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

**Please state the actions you have taken or are planning to take:**
A nurse facilitator has been recruited and a comprehensive training schedule has been put in place.
Action Behaviour and Consequence training is currently ongoing.
Supporting documentation and recording procedures are now in place.
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<tr>
<th><strong>Proposed Timescale:</strong> 30/09/2015</th>
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<tr>
<td><strong>Theme:</strong> Safe care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Positive behaviour support plans had not been developed for residents to ensure a proactive approach in the management of behaviour that is challenging.

**Action Required:**
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

**Please state the actions you have taken or are planning to take:**
Behavioural support plans are being introduced based upon (management of actual or potential aggression) MAPA Crisis development model. This model will be used in conjunction with the aforementioned ABC recording tool.

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<td><strong>Theme:</strong> Safe care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Restrictive practices, including bedrails and single separation, were not used in line with national policy published by the Department of Health.

**Action Required:**
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**
Cahermoyle House endeavour to work towards a restraint free environment as advocated by the department of health national policy. Instructions given to staff by the previous clinical psychologist conflict with the information in the letter referenced in this report over whether the resident should be left alone or not for the first 10 minutes of “time out”. The current clinical psychologist will attend on 25/08/2015 to review and clarify the situation. A planned approach to “time out” will be put in place, which will clearly define the parameters for “time out” as agreed with the current clinical psychologist. Comprehensive records will be maintained in relation to any therapeutic intervention going forward.
### 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 system for completing risk assessments required review. Some identified hazards did not have associated risk assessments. Other risk assessments required improvement.

For example, there was no risk assessment for the absence of stair-gates at the top of stairs leading to the upstairs bedrooms. The infection control risk assessment did not include hand hygiene training or auditing of practice as a control. There was no risk assessment for the risk posed by a threshold step in each en-suite shower in the ‘West Wing’. The manual handling risk assessments were inadequate.

**Action Required:**
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**
Risk register has been further developed and all identified risks have been assessed and updated.
There is an ongoing process of improvement
Wooden gates have now been reinstated and fixed securely at the top of all staircases leading to upstairs bedrooms. Gates as permanent fixtures are currently being sourced; these will include touch pads for added security and will comply with current fire regulations.
We will implement “I AM’s” or “New To Me’s”. These documents will include guidance on manual handling. Each resident’s I AM will be located in the resident’s room.

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### Proposed Timescale: 30/09/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The system for reviewing the effectiveness of controls required review.

For example, the majority of risks in the risk register were rated at the level of ‘extreme’ or ‘high’ and there was no residual risk rating following implementation of controls in place. The system for reviewing the effectiveness of such controls required review. In addition, the inspectors found that the level of risk to residents posed by the absence of
stair-gates at the top of stairs leading to the upstairs bedrooms and the threshold steps in the en-suite showers of the ‘West Wing’ was not acceptable and these significant hazards needed to be addressed.

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

**Please state the actions you have taken or are planning to take:**
Risk register has been further developed and all identified risks have been assessed and updated.
There is an ongoing process of improvement

**Proposed Timescale:** 30/09/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Further improvement was required to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. While the centre had an infection control policy in place, staff required training in relation to how to implement the procedures, including training in hand hygiene and how to prevent and manage healthcare associated infections. Hand hygiene and infection control audits were not currently in place. The infection control risk assessment required review.

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

**Please state the actions you have taken or are planning to take:**
The nurse facilitator has put in place training for standard precautions for infection control.
All staff are now receiving training within the area of infection control. An infection control policy and procedure is in place.

A folder has been put in place that contains the following:
Infection prevention and control manual.
National standards for the prevention and control of healthcare associated infections.
Core infection prevention and control knowledge and skills.
Norovirus information and management.
Guidelines for hand hygiene.
A training session for the above is scheduled for 16/09/2015
Multiple Infection control audit procedures including room audits, kitchen audits, hand hygiene audits, disposal of clinical waste audits and resident infection history audits are currently being developed.

MRSA protocols are in place and will be audited.

**Proposed Timescale:** 30/09/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The fire extinguishers were overdue the annual service since 14/4/2015 (13 weeks prior to the inspection). In addition in the ‘West Wing’, the fire doors in the toilet and bathroom had been negated as holes were observed in those doors.

**Action Required:**
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
Fire extinguishers now comply with regulatory requirements.
We are currently sourcing emergency evacuation equipment.
The issues with gaps in fire doors is currently being addressed

**Proposed Timescale:** 06/09/2015

**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:**
Medicines requiring refrigeration were not stored securely.

**Action Required:**
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

**Please state the actions you have taken or are planning to take:**
All medication is now stored securely
Proposed Timescale: 07/07/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A medication error was identified by an inspector where medicines potentially were not given as prescribed.

**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:**
A new format of medication administration and recording of same is currently being introduced in conjunction with the pharmacy this combined with regular and random audit process will ensure best practice is maintained.

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Proposed Timescale: 31/10/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
References and resources available were not complete to allow those administering medicines to confirm and identify individual medicines in the monitored dose system.

**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:**
A new format of medication administration and recording of same is currently being introduced in conjunction with the pharmacy this combined with regular and random audit process will ensure best practice is maintained.
As part of the above changes a comprehensive tic-tac system will be introduced along with new multi disciplinary medication check in system.

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Proposed Timescale: 31/10/2015

**Outcome 11: Health and Social Care Needs**
**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre did not meet the assessed needs of all residents. Where this had been found to be the case, it had not been demonstrated that steps had been taken to progress this since the previous inspection.

**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:**
Where the centre is unable to fully meet the needs of a resident we shall endeavour to actively seek a more suitable placement for that resident.
Where HSE indicate to us that resources are not available to assist us to meet these needs we will ensure that we provide the best care possible.
Where there is a clear gap in the care pathway we will ensure that this is clearly communicated to all the health care professionals in order to promote best outcomes.
Specific information relating to the resident in question will be forwarded directly to the inspector.

Proposed Timescale: Ongoing 01/09/2015

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**Proposed Timescale:** 01/09/2015

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A comprehensive assessment of residents' social care needs had not been satisfactorily completed for all residents and care planning required further improvement.

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

**Please state the actions you have taken or are planning to take:**
We continue to move all care planning to the epic system of recording.
All new care plans will be entered onto the epicare system all other existing paper based care plans will be transferred as they are reviewed.

Proposed Timescale: 31/10/2015
**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:**
The premises did not fully meet the requirements under Schedule 6 of the Regulations. For example: in the communal area on the ground floor, there was an insufficient number of toilets; on the first floor of the West Wing grab-rails had not been fitted in the shower of the unoccupied double room and the shower trays in every shower on this floor had a threshold step that residents had to step over to access the shower. In the (vacant) double bedroom in the West Wing, exiting in the event of an emergency necessitated climbing three steps, traversing a room and descending four steps to exit via the dedicated fire exit. As a result, no resident residing in this room would be able to have any degree of mobility or cognitive impairment and would need to be fully independent. On the first floor of the East Wing, screening in the two double bedrooms was inadequate. The layout of the bed in one double bedroom was not acceptable. The bedrooms on the first floor of the East Wing were confined in terms of space and were not suitable for any resident who required assistive or adaptive mobility aids or appliances. There were no stair-gates in place in both East and West Wings, as required.

**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:**
Work is due to commence within the next eight weeks in order to provide a further two toilets to the ground floor area.
Grab rails will be installed to the shower in the currently empty room before it is occupied.
Shower trays will be levelled to all rooms where they are currently raised.
No resident will be considered for the double room in the west wing who has any degree of cognitive or physical deficit until alternative fire exit can be established that meets with fire regulations.
The 2 additional Bathrooms to be completed by 20/09/2015. The Shower trays to be removed between the 01/09/2015 and completed by 15/10/2015.
There is a written risk assessment in relation to ensuring that no resident will be considered for the double room in the west wing that has any degree of cognitive or physical deficit.

**Proposed Timescale:** 31/10/2015

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**Outcome 13: Complaints procedures**

**Theme:**
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<thead>
<tr>
<th>Theme:</th>
<th>Person-centred care and support</th>
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<tbody>
<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
<td>The person nominated as the independent appeals person did not meet the requirements of the Regulations. Clarity was required to the complaints procedure to ensure that it clearly outlined how complaints are managed in the centre.</td>
</tr>
<tr>
<td>Action Required:</td>
<td>Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>A new external and independent appeals representative has been located and is now documented as such.</td>
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<tr>
<td>Proposed Timescale:</td>
<td>03/08/2015</td>
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<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
<td>The screening in two double bedrooms was still not adequate as screens were of a plastic material and were not sufficiently long from ceiling to floor. One screen did not fully close on one side.</td>
</tr>
<tr>
<td>Action Required:</td>
<td>Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>New screening has been supplied</td>
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<tr>
<td>Proposed Timescale:</td>
<td>01/09/2015</td>
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<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
<td>Formal consultation processes had yet to commence and required further consideration</td>
</tr>
</tbody>
</table>

Page 33 of 35
in relation to how residents’ who chose not to participate in such meetings would be consulted with or represented.

**Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

**Please state the actions you have taken or are planning to take:**
There is a new resident forum which met on Thursday 13th August and will meet thereafter on a two monthly basis at which all matters relating to the home can be discussed. Activity staff will relay information following each residents’ forum via a newsletter which will be circulated within the home within two weeks of the forum meeting.

Proposed Timescale: Next residents’ forum meets 15/10/2015. Newsletter by 29/10/2015

**Proposed Timescale:** 29/10/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Further work was required to identify residents who may require an advocate and to ensure that such residents had access to such services.

**Action Required:**
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

**Please state the actions you have taken or are planning to take:**
Sage advocacy service is now being actively promoted named nurses are aware of the service and posters and flyers are randomly distributed for resident and relative information. Sage advocate has been contacted and invited to identify residents who may not otherwise have the opportunity to avail of advocacy services.

**Proposed Timescale:** 01/09/2015

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
At this inspection, it was also found that where communication needs had been identified, they had not always been fully met.
Action Required:
Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident’s care plan prepared under Regulation 5.

Please state the actions you have taken or are planning to take:
The specific resident mentioned is no longer nursed within the home. In future if any resident has special communication requirements these will be recorded in their communication care plan which along with other care plans will be regularly and randomly audited as part of the new robust quality control mechanism.

Proposed Timescale: 28/07/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The centre’s training records showed that staff did not have up to date mandatory and additional training, assessed as being appropriate.

Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
A new training matrix has been developed and is currently kept up to date by the newly appointed nurse facilitator.

Proposed Timescale: 17/08/2015