<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Swords Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000181</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Mount Ambrose, Swords, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 890 0089</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:swords@mowlamhealthcare.com">swords@mowlamhealthcare.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
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<tr>
<td>Provider Nominee:</td>
<td>Pat Shanahan</td>
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<tr>
<td>Lead inspector:</td>
<td>Jim Kee</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary O'Donnell</td>
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<tr>
<td>Type of inspection:</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 17 August 2015 07:10  
To: 17 August 2015 18:15

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

<table>
<thead>
<tr>
<th>Outcome</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
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</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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**Summary of findings from this inspection**

This was an unannounced inspection of the centre to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. During this inspection the inspectors also reviewed issues raised by recent unsolicited information received by the Authority, and notifications submitted to the Authority by the centre.

The designated centre provides long term care for older persons and there were 54 residents residing in the centre on the day of the inspection. Inspectors found evidence of good practice in all of the 12 outcomes inspected against, with five outcomes deemed to be fully compliant with the Regulations including the outcomes on the person in charge, health and safety and risk management, complaints, end of life care, and residents' clothing and personal property and possessions. Inspectors found that there were systems in place to ensure good management of complaints, and that residents could maintain control over their individual property and
possessions. Recent falls within the centre were reviewed and inspectors formed the view that there was appropriate management of the risk of falls within the centre.

The centre was found to be in moderate non compliance with 7 of the outcomes, including governance and management, safeguarding and safety, medication management, health and social care needs, premises, food and nutrition and suitable staffing. The action plan at the end of the report identifies the areas within these 7 outcomes where improvements were required in order to comply with the Regulations.
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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
Overall the inspectors found that there were effective management systems in place and sufficient resources available to ensure the delivery of safe, quality care services. The annual review of the quality and safety of care as required by Regulation 23 had not been completed at the time of the inspection.

There was a clearly defined management structure in place, and staff were familiar with the reporting structure within the centre. The person in charge was not present on the day of the inspection, but there was a clinical nurse manager in charge of the centre. Quality and clinical governance committee meetings were held on a regular basis to discuss a range of issues including staff training, falls, complaints, and audits of infection control, health and safety, catering, medication management, and clinical documentation. Surveys of resident and relative satisfaction had also been conducted. The registered provider had not conducted an annual review of the quality and safety of care delivered to residents to ensure that the care being delivered within the centre was in accordance with relevant standards set by the Authority.

Judgment:
Non Compliant - Moderate

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 was the director of nursing, a registered nurse and worked full time within the centre. The person in charge was on a rostered day off on the day of the inspection but had been interviewed previously by the Authority and was deemed to have the required knowledge and experience to hold the post of person in charge.

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

**Findings:**
Measures were in place to protect and safeguard residents which included a policy on, and procedure in place for, the prevention, detection and response to abuse. Residents told inspectors that they felt safe. There were systems in place to ensure that incidents, allegations or suspicions of abuse were recorded and appropriately investigated. Training records provided evidence that all staff had attended training on safeguarding, which included information on the types of abuse and responding to allegations of abuse. Staff interviewed was able to describe their duties and responsibilities were if they suspected abuse and there was evidence that suspicions of financial abuse by persons external to the service had been reported in line with the policy. Inspectors noted that three residents who had a history of behaviours, that might place other residents at risk were appropriately supervised and had a single bedroom. This issue had been addressed satisfactorily since the previous inspection. However the policy had not been updated since Feb 2013 and did not reference the national policy published in 2015. There was a system in place to ensure incidents, allegations or suspicion of abuse were appropriately recorded and investigated, and that measures were put in place to ensure residents' safety.

There was a robust policy in place to safeguard residents money. Inspectors went through a sample of resident’s finances with staff and found there were clear, concise records and receipts in place to reflect the individuals outgoing and incoming cash. Safe and secure storage was available. The process in place reflected the policy.
A restraint free environment was promoted with relevant policies and procedures informing practice. The number of bed rails in use had been reduced to seven and many of the residents had been provided with low-low beds and crash mats. The use of bed rails was reviewed on a regular basis and residents were involved in decisions about the use of bedrails. Inspectors held the view that the documentation of the rationale for decisions to continue to use or to reintroduce bed rails could be improved.

As mentioned already, three residents presented with behaviours that challenge. There was a policy on responsive behaviours and staff had training to support the implementation of the policy. However not all of these residents had a positive behaviour support plan to support a consistent approach by staff to the management of these residents. There was documentary evidence that staff used non restrictive distraction techniques to successfully de-escalate these behaviours, and sometimes residents were administered medications to control these behaviours. Staff did not have clear guidance as to when PRN (as required) medication should be administered. These issues were found at the previous inspection and had not been addressed.

**Judgment:**
Non Compliant - Moderate

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

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

**Theme:**
Safe care and support

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

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

The centre had an emergency plan in place which provided information to guide staff on the procedures to follow in the event of evacuation. The plan provided detailed information with regard to evacuation procedures, alternative accommodation and transport. It also addressed emergencies such as loss of heat, power or water supply.

There was a centre-specific risk management policy which addressed all the risks specified in the Regulations as well as the procedures in place for the identification and management of risk. There was a safety statement in place and the associated risk register was regularly reviewed by the provider, the person in charge and the health and safety representative. There was documentary evidence of monthly checks for environmental risks and a system was in place to monitor the effectiveness of the measures put in place to mitigate risk. Inspectors found that procedures were in place to promote the health and safety of residents, staff and visitors. There were minutes to
show that issues regarding health and safety were discussed at the clinical governance meeting and at staff meetings.

The inspector reviewed fire safety procedures and associated records. Fire orders were prominently displayed, fire exits were unobstructed and staff members, spoken with by inspectors, were knowledgeable with regard to the procedures to follow in the event of fire. The training records showed that all staff had up-to-date training in this area and records were also in place to show that regular fire drills took place. Fire drills also simulated night time conditions. Inspectors also reviewed the records with regard to servicing of equipment. The records showed that there was regular servicing by external consultants of the fire detection and alarm system and of fire fighting equipment. A documented system of in-house checks on fire exits and the fire detection system was also in place.

Systems were in place for the recording and learning from accidents, incidents and near misses. Detailed records of all accidents were maintained and there was evidence of learning to prevent reoccurrence. Neurological observations were carried out in the event of any unwitnessed fall or possible injury to the head. All accidents and incidents were reviewed by the person in charge and discussed with the staff in order to identify any further interventions to prevent reoccurrence. The inspector saw that there was a proactive system of falls management system in place. Each resident’s falls risk was routinely assessed and risk reduction measures such as low beds, sensor alarms, and hip protectors were provided as appropriate. The inspector reviewed the records of two residents who had a frequent fall. The inspector saw that both residents had a post falls assessment which included a physiotherapy assessment and a review of their medications. They had appropriate care plans in place which was being implemented and targeted interventions such as sensor mat and low bed had been put in place. Inspectors saw that arrangements for close supervision of these residents were implemented.

There was an infection control procedure in place. Nursing staff and care assistants were observed following correct hand hygiene and all staff had access to gloves, hand gels and aprons. Staff members had received training in infection control and were knowledgeable about the procedures to follow to prevent the spread of infection. However a recently employed laundry staff member who laundered clothing for residents who were MRSA positive had not been given adequate information on infection control in relation to laundry duties.

The training matrix showed that staff had up-to-date training in moving and handling. Residents’ moving and handling assessments were routinely assessed and instructions for assisting residents to mobilise were available in the care planning documentation which was readily accessible to the appropriate staff.

**Judgment:**
Compliant

**Outcome 09: Medication Management**

Each resident is protected by the designated centre’s policies and procedures
**Theme:**
Safe care and support

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

**Findings:**
Residents were protected by the centre's policies and procedures for medication management but some improvements were required in relation to documentation, and the use of PRN (as required) medicines within the centre.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of individual pouches were appropriate. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. The inspector did observe that during administration rounds there was a system of storing a number of residents' medicine pouches on a storage area on top of the medication trolley. Nursing staff were vigilant in ensuring that the trolley was always within sight, and that it was never left unattended in corridors. However the inspector had concerns regarding the security of this system if the nurse was required urgently, as these medicines could not be quickly and easily secured within the trolley.

Inspectors observed nursing staff administering medicines to residents during the morning administration rounds. The nurses knew the residents well, and were familiar with the residents' individual medication requirements. Inspectors observed that the nurses took time to greet each resident, checked how they had slept, ensuring they were comfortable before administering their prescribed medicines. Nurses were observed to use alcohol hand gels appropriately throughout the process. Medication administration practices were found to adhere to current professional guidelines.

Medication management audits were conducted within the centre as part of the quality and clinical governance system in place. Staff confirmed that pharmacists from the pharmacy who supplied medicines to the centre were facilitated to visit the centre and meet their obligations to residents as required by the Pharmaceutical Society of Ireland. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

The inspectors reviewed a number of the prescription and administration sheets and identified a number of issues that did not conform with appropriate medication management practice:
- A number of residents required their medicines to be crushed prior to administration and this was documented on a separate page within the medication folder. The
prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.

- The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines and in some cases only the times of administration had been ticked. (the prescription did not indicate if the medicine was to be administered once daily or twice daily etc.)
- The indication for use of PRN (as required) medicines was not consistently documented on the prescription sheet and there were no associated resident specific care plans in place for these medicines to guide staff in the administration of these medicines (in some cases residents had been prescribed more than one psychotropic medicine on a PRN basis but the prescription did not indicate when the medicines were to be used or which medicine was to administered first and there were no protocols in place to guide practice to ensure appropriate consistent administration)
- The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet.

Judgment:
Non Compliant - Moderate

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 each resident’s wellbeing and welfare was maintained by a high standard of nursing care and appropriate medical and allied health care. Issues previously identified in relation to the management of nutrition had not been satisfactorily addressed

Residents’ needs were comprehensively assessed on admission and regularly assessed thereafter. There assessed needs were set out in individual care plans with evidence of resident or relative involvement at development and review. Inspectors found that care plans were not consistently updated as a residents condition changed, or at four monthly intervals. One highly dependent resident did not have his care plan updated for a week following a period of hospitalisation. The previous inspection found that care plans had not been developed based on up-to-date nutritional assessments and this matter had not been addressed. Inspectors followed up on 10 residents and found that
three residents who had experienced recent unintentional weight loss, did not have a planned nutritional assessment review done and the review date had expired by over two weeks. This issue is discussed further under Outcome 15.

The inspector found significant improvement was required with regard to the management of nutrition. There were systems in place to assess residents for signs of poor hydration and nutrition and all residents were weighed monthly. Residents identified at high risk of poor nutrition were reviewed by the dietician and food fortification and supplements were provided as appropriate. Poor monitoring of weight records is discussed under Outcome 15. In addition, inspectors found that for one resident who had a pattern of weight loss, the centre’s policy had not been followed and an appropriate plan had not been put in place to address and manage this need. The failure to meet his nutritional needs may have contributed to the development of a pressure sore or delayed healing.

The inspector reviewed the management of other clinical issues such as wound care, falls management, dementia care and found they were well managed and guided by appropriate policies. Improvements were required in the management of behaviours that challenge and this is discussed under Outcome 7. Residents had access to a range of allied health professionals and specialist hospital services. Physiotherapy services were provided three days each week. Optical and podiatry services were provided on site on a regular basis. Inspectors were informed that HSE dental services had been withdrawn since January 2015 and no alternative arrangements were made for three residents who required dental services.

Each resident had opportunities to participate in meaningful activities and the activity programme was based on residents’ assessed interests and capabilities. There was a varied programme of activities on offer led by an enthusiastic activities coordinator and residents spoke positively of the choices available. There was also choice for residents who had dementia or communication difficulties and this included a range of one on one activities. Residents were facilitated and supported to be independent where ever possible. This could be improved if they had access to a larger secure outdoor area. This is discussed further under Outcome 12.

**Judgment:**
Non Compliant - Moderate

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### Outcome 12: Safe and Suitable Premises

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

**Theme:**
Effective care and support

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

**Findings:**
The inspectors only reviewed certain aspects of the outcome relating to premises, including the laundry and the outdoor space.

The inspectors observed that the centre was clean and well maintained on the day of the inspection, and there had been no changes to the premises since the last inspection.

The laundry was located in a separate building and the layout and space available within the laundry was not adequate to ensure sufficient separation of clean and dirty laundry at all times. There was only one doorway through which the laundry had to pass, and there was no space to facilitate an appropriate flow system to prevent contamination of clean laundry and maintain infection control measures.

There were a number of areas laid out in lawn surrounding the centre but there was only one small secure enclosed area to which residents had open access via the sun room. This enclosed space was not sufficient to meet the needs of the number of residents that were residing in the centre.

**Judgment:**
Non Compliant - Moderate

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**Outcome 13: Complaints procedures**

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

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

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

**Findings:**
There was a complaints policy which met regulatory requirements. The policy was displayed at the entrance and a copy was included in the residents guide. Residents and relatives could identify the person in charge as the complaints officer they would contact if they had an issue or a complaint. Inspectors reviewed the complaints records, which included details of the investigation and outcome and also indicated if the complainant was satisfied with the outcome of the complaint. There was evidence that improvements were implemented to ensure the issues within the complaint did not re-occur.

Complaints were discussed at management meetings and there was a nominated person who ensured that all complaints were appropriately responded to.

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

**Findings:**
The centre had a policy in place on end of life care which informed practice.

The policy on end of life care addressed all physical, emotional, spiritual and social needs of residents at end of life, and promoted respect and dignity for dying residents. On the day of inspection there was one resident receiving end of life care, and the GP visited the resident and decided to arrange for the transfer of this resident to the hospital.

The inspectors reviewed a number of end of life care plans, a number of which had not been updated as required by the Regulations as outlined previously in Outcome 11. The care plans facilitated the resident and family members to express their needs and wishes for end of life care. The centre had access to specialist palliative care services provided by a local hospice.

**Judgment:**
Compliant

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**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:**
Residents received a varied and nutritious diet that was tailored to meet individual preferences and requirements. However, some improvement was required in the maintenance of the care plans and communication with the kitchen staff about specialist
dietary advice.

There was a food and nutrition policy in place which was centre specific and provided detailed guidance to staff. Staff members spoken to by the inspector were knowledgeable regarding this policy.

The inspector observed the service of breakfast and the main meal to residents. Residents had a choice of being served breakfast in their rooms or in the dining/day areas. Residents, spoken to by the inspector stated that they enjoyed the breakfast provided and they were offered choice including boiled eggs, porridge and a variety of cereals. The inspector also observed the main meal and found that it was hot and attractively presented. Residents were offered a choice of food at each meal time and individual preferences were readily accommodated.

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 as the main meal. Water was accessible to all residents and regular hot and cold fluids were provided during the day. Portion sizes were appropriate. Many of the residents who required assistance at this meal received this in a sensitive manner.

Residents who required specialised diets and altered consistency meals were facilitated and staff members were aware of individual resident’s requirements. Residents who required dietary restrictions due to cultural or medical grounds were facilitated, such as diabetic diets. Inspectors saw that advice from the dietician was not consistently implemented for individual residents. The communication between the chef and the nursing staff regarding residents needs required improvement, the chef was not fully aware of residents who required high protein, high calorie diets.

Overall there were care plans for nutrition and hydration in place. While the nutritional needs of residents were mostly being met, care plans for residents who had lost weight recently did not fully direct the care to be delivered and were not always updated when the resident’s condition deteriorated. Inspectors also noted two cases where the wrong weight was recorded but these residents were not reweighed. The action plan for these matters is included under Outcome 11.

There was a varied menu plan in place, which was externally audited by the dietician in order to ensure that it was nutritionally balanced and residents had access to speech and language and dietetic services.

The inspector spoke to many residents regarding food and nutrition. Overall the response was uniformly positive with residents expressing a high level of satisfaction with the choice of food, the meal times and the overall dining experience. Residents stated that they could request additional snacks or drinks if they were feeling hungry.

Staff had received training in the area of nutrition and was knowledgeable. All staff involved in assisting at mealtimes had training in food handling. Chefs had HASSAP training.

The inspector visited the kitchen and found that it was maintained in a clean and
The complaints for 2015 were reviewed and they did not relate to food or meals.

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

**Findings:**
There was a robust system in place within the centre to ensure that residents could retain control over their own possessions including clothing.

Residents' clothing was labelled, and detailed records were maintained of each resident's individual property and possessions. Adequate storage was provided within residents' rooms for storage. Residents could have their laundry attended to within the centre. The inspectors' concerns regarding the laundry are outlined in Outcome 12.

**Judgment:**
Compliant

**Outcome 18: Suitable Staffing**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
Inspectors found that there were sufficient staff numbers and skill mix to meet the assessed needs of the residents at the time of the inspection, although inspectors did have concern regarding the rostering of nursing staff at night, and the system in place to ensure that risk was appropriately managed while awaiting garda vetting for staff.

The inspectors met with the night staff on the morning of the inspection. There was one registered nurse on duty, and one pre reg nurse who was currently awaiting registration with the Nursing and Midwifery Board of Ireland (NMBI) (Bord Altranais agus Cnáimhseachais na hÉireann). The registered nurse had only recently completed induction training within the centre, and was in charge of the centre from 8pm to 8am. Review of the staff rosters indicated that the rostering of one registered nurse with one pre reg nurse had occurred on a regular basis over the past few weeks. There had been a number of staffing changes within the centre, and this issue had been raised with the inspectors.

Inspectors reviewed the education and training schedule for staff and found that a broad range of training had been provided including fire safety, moving and handling, end of life, falls prevention, nutrition, elder abuse, infection control, CPR, dementia, syringe pump workshops and continence awareness training. This investment in education and training had ensured that staff were competent to deliver care, but recent staffing changes may have contributed to issues with care plans as outlined previously. Staff working in the laundry had not received appropriate induction training to ensure policies and procedures for the management of laundry were followed.

Staff were supervised appropriate to their role, and there was a clear management structure within the centre, with defined roles and responsibilities, that included the person in charge, two clinical nurse managers, staff nurses, senior health care assistants and health care assistants. There was a formal system of staff appraisal that included regular 1:1 meetings with staff.

There were no volunteers working in the centre at the time of the inspection. The inspectors reviewed a number of staff files, and found that the nursing staff files reviewed contained up to date registration numbers. Two of the staff files viewed by inspectors did not contain evidence of Garda vetting as required by the Regulations. Inspectors were informed that the required documents had been submitted, and that there was a delay in obtaining the necessary Garda clearance. The staff members concerned had been working in the centre for a number of months, and had signed a self declaration document. There was no system in place within the centre to ensure that risk associated with such recruitment practices was managed appropriately.

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:

Jim Kee
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report¹

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<td>17/08/2015</td>
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<tr>
<td>Date of response:</td>
<td>25/09/2015</td>
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Requirements

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

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

Outcome 02: Governance and Management

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The registered provider had not conducted an annual review of the quality and safety of care delivered to residents to ensure that the care being delivered within the centre was in accordance with relevant standards set by the Authority.

**1. Action Required:**
Under Regulation 23(d) you are required to: Ensure there is an annual review of the

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¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:**
An annual review of the quality and safety of care delivered to residents has been conducted by reviewing the internal audits and action plans carried out over the past 12 months; the review includes an analysis of clinical and environmental risks, adverse incidents, events and feedback from residents and relatives (including complaints and satisfaction survey). An action plan to address the findings has been compiled. The review will be presented at a Quality & Governance Annual Review meeting in the centre on 29th September 2015.

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

<table>
<thead>
<tr>
<th>Outcome 07: Safeguarding and Safety</th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td>Safe care and support</td>
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<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>Residents did not have positive behaviour support plans to support a consistent approach by staff to the management of these residents.</td>
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<tr>
<td><strong>2. Action Required:</strong></td>
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<tr>
<td>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.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<tr>
<td>A thorough review of care plans has been undertaken for residents with responsive behaviour. There are focused care plans to address individual residents who display challenging behaviour. The PIC has ensured that staff are aware of individualised plans of care in order to ensure a consistent approach to the management of these residents.</td>
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<td><strong>Proposed Timescale:</strong> 30/09/2015</td>
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<tr>
<th>Outcome 09: Medication Management</th>
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<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td>Safe care and support</td>
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<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>The storage of all residents’ medicines on the medicines trolleys during the medication</td>
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administration rounds requires review to ensure that the medicines stored on top of the trolley are secure at all times, particularly if the nurse has to leave the trolley in the event of an emergency.

3. 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:
A review of medication management is under way in the centre. As part of this review, medications are stored securely at all times and there is no storage of medicines on top of the trolley.

Proposed Timescale: 30/09/2015
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors identified a number of issues that did not conform with appropriate medication management practice:
- A number of residents required their medicines to be crushed prior to administration and this was documented on a separate page within the medication folder. The prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
- The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines and in some cases only the times of administration had been ticked. (The prescription did not indicate if the medicine was to be administered once daily or twice daily etc.)
- The indication for use of PRN (as required) medicines was not consistently documented on the prescription sheet and there were no associated resident specific care plans in place for these medicines to guide staff in the administration of these medicines (in some cases residents had been prescribed more than one psychotropic medicine on a PRN basis but the prescription did not indicate when the medicines were to be used or which medicine was to administered first and there were no protocols in place to guide practice to ensure appropriate consistent administration)
- The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet.

4. 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:
As part of the review of medication management in the centre, the GP will be requested
The time, frequency and maximum dosage of all medicines is indicated on all prescription charts. The indication for use of PRN medicines is documented on prescription charts. The care plans of residents for whom psychotropic medicines are prescribed are individualised, indicating clearly when each medicine is to be used, so as to ensure consistency and appropriateness of administration. The maximum daily dose of all PRN medicines is indicated on prescription charts.

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

### 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:**

Three residents who had experienced recent unintentional weight loss, did not have a planned nutritional assessment review done and the review was more than two weeks overdue.

**5. 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:**

The PIC is coordinating a review of the nutritional status of all residents who are at risk of weight loss by the nurses and the dietitian. Each resident at risk has an individualised focused care plan for nutrition in place. All residents’ weights are displayed graphically on the electronic resident record, so that any trend towards weight loss or gain can be viewed clearly.

A system of review has been put in place and a daily check is in place along with the introduction of a Nutritional Risk Register to be completed weekly to ensure that all aspects of the nutritional needs of these residents are monitored, communicated and reviewed appropriately.

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

**Theme:** Effective care and support

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

Inspectors found that care plans were not consistently updated as a residents condition...
changed, or at four monthly intervals.

6. **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:**
All assessments and care plans will be reviewed and updated as required and at least at 4 monthly intervals.

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

**Theme:**
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found significant improvement was required with regard to the management of nutrition as detailed in Outcome 15.

HSE dental services had been withdrawn since January 2015 and no alternative arrangements were made for three residents who required dental services.

7. **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:**
The regular dental service previously supplied to the centre by the HSE has been withdrawn. The PIC is attempting to source an alternative dental service and/or a ground floor dental surgery where those residents who are able can visit for appointments.

**Proposed Timescale:** 30/11/2015

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 secure outdoor space accessible to residents from the sun room was not sufficient
to meet the needs of the number of residents that were residing in the centre.

8. **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:**
We will enclose another external area between wings to create an external space to facilitate residents requiring access to secure external space.

**Proposed Timescale:** 31/03/2016

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The layout and space available within the laundry was not adequate to ensure sufficient separation of clean and dirty laundry at all times or to facilitate an appropriate flow system to prevent contamination of clean laundry and maintain infection control measures.

9. **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:**
All laundry is outsourced, apart from the residents’ personal items of clothing. There is a new laundry assistant in post and she has received training on the appropriate segregation of clean and dirty laundry items in order to maintain effective control measures.

Previous measures have been taken to completely reconfigure the layout of the laundry as a planned action following previous inspection. Further measures taken include a “clean laundry” trolley with individual compartments for clean clothing which is in place, and a system of coloured bags is in place for unclean items; these are only brought into the laundry at the time of being laundered in the washing machines.

**Proposed Timescale:** 25/09/2015

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**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:
Advice from the dietician was not consistently implemented for individual residents. The communication between the chef and the nursing staff regarding residents needs required improvement, the chef was not fully aware of residents who required high protein, high calorie diets.

10. 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:
The PIC is implementing improvements in communications between the nurses and carers, chef and dietician in the centre, in order to ensure a consistent and appropriate plan of care for all residents, especially those who may be at risk of malnutrition. All residents are provided with adequate quantities of food and drink, based on nutritional assessment in accordance with each resident’s individual plan of care.

A Nutritional Risk Register will be completed weekly to ensure that all aspects of the nutritional needs of these residents are monitored, communicated, care planned and reviewed appropriately.

Proposed Timescale: 30/10/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no system in place within the centre to ensure that the risk associated with staff currently awaiting Garda clearance working within the centre was managed appropriately, including appropriate supervision practices.

11. 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:
Appropriate supervision practices are in place for all newly recruited staff to ensure that residents’ safety is maintained and that the care they receive a high standard of care. Reference checks are carried out and staff have signed a self declaration form, attesting to their integrity, while the Garda Clearance outcome is pending.
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<th>Proposed Timescale: 25/09/2015</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Workforce</td>
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</table>
| **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Staff working in the laundry had not received appropriate induction training to ensure policies and procedures for the management of laundry were followed.  

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

**Please state the actions you have taken or are planning to take:**  
The laundry staff have received appropriate induction training to ensure that policies and procedures for the management of laundry are followed.

| Proposed Timescale: 25/09/2015 |