<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Fatima Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000264</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Oakpark, Tralee, Kerry.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>066 712 5900</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@fatimahome.com">info@fatimahome.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>Dominican Sisters</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Sr. Teresa McEvoy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Aoife Fleming</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Noelle Neville; Vincent Kearns</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>64</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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: 21 July 2015 09:00
To: 21 July 2015 18:30

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

<table>
<thead>
<tr>
<th>Outcome Description</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Absence of the 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>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</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 - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
</tr>
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Summary of findings from this inspection
This was the sixth inspection of Our of Fatima Home by the Authority. The inspection was unannounced and took place over one day. The purpose of the inspection was to monitor on-going compliance and to follow up on the actions from the previous registration inspection in November 2013. On the day of the inspection there were 2 vacancies at the centre. As part of the inspection process inspectors met with the nominated provider, staff, residents and visitors in the centre. The person in charge was on leave at the time of the inspection and the inspectors met the person participating in management who was nominated to oversee the running of the centre. Inspectors observed practices and reviewed documentation such as care plans, medical records, training records, staff files, the complaints and incidents log and relevant policies. The findings of the inspection are set out under twelve Outcome statements. These outcomes are based on the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People)
Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All of the actions of the previous registration inspection in November 2013 had been addressed. The inspectors found that the premises and equipment were well maintained in the centre, however some improvements were required to maintain a safe environment for residents and infection control processes in the centre.

On the day of inspection an immediate action plan was issued to the person participating in management regarding inadequate controls to prevent the risk of fire in the centre due to inadequate arrangements to safeguard a resident while smoking. A satisfactory response was received by the close of the inspection.

Actions were required in the areas of Health and Safety and Risk, Medication Management and care planning.
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):
No actions were required from the previous inspection.

Findings:
The centre had a person in charge and a nominated person participating in management to oversee the day to day running of the centre. However, at the weekend and at night-time it was unclear who was the accountable person when the aforementioned staff were off duty. It was deemed to be the most senior nurse on duty however, this person was not named or identified for each shift. The handover of information which occurred every morning took place in a sitting room in the centre and was attended by all staff however, this arrangement meant that some wards were left unmonitored. Inspectors formed the view that this method of communication posed a potential risk to residents in the centre.

There was evidence of regular audits conducted in the centre over recent months in the areas of care plans, falls, dysphagia, incontinence and medication. Actions were identified as a result of these audits and these actions formed the basis for further re-audit to ensure implementation. However, there was no annual review of the quality and safety of care and the quality of life of residents in the centre as required by Regulation 23.

Judgment:
Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
This outcome was addressed in so far as addressing the findings relating to the requirements of Regulation 21(1), Schedules 3(4)(d) and Schedule 4 which were found during the course of the inspection.

The copy of the Statement of Purpose made available in the main reception of the centre was not the most up to date version, as required by Schedule 4, as it was dated 2012. A Statement of Purpose dated 2013 had been submitted to the Authority with the centres last registration application in 2013.

The system for recording the administration of medications on the medication administration record (MAR) was not adequate or in accordance with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management, as required by Schedule 3(4)(d). The detail regarding this action is outlined under Outcome 9 Medication Management.

Where detailed recommendations had been made by the dietician regarding a resident who was losing weight however, this information had not been updated on his current food and nutrition care plan. This system of recording was not in line with best practice as set out in An Bord Altranais agus Cnáimhseachais na hEireann "Recording Clinical Practice Guidance for Nurses and Midwives". This was also outlined under Outcome 11 Health and Social Care Needs.

The inspectors viewed a sample of staff files and found that not all the requirements of Schedule 2 of the Regulations were in place. Not all staff had outlined a full employment history and a vetting disclosure from an Garda Siochana was not in place for a new member of staff.

Inspectors reviewed records of residents’ finances in the centre as discussed in Outcome 7 Safeguarding and Safety. However, as required by Schedule 3(5)(b)(i) the purpose for which money was used was not always documented for each transaction where applicable.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
Theme:
Governance, Leadership and Management

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

Findings:
At the time of inspection the person in charge was on leave and this role was covered by the nominated person participating in management. This arrangement had been notified to the Authority as required. The person participating in management was aware of her regulatory responsibilities with regard to notifications and was suitably involved in the day to day management of the centre and displayed a detailed knowledge of residents and activity in the centre.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
The centre had an up to date policy for the prevention, detection and response to abuse. Staff spoken with were knowledgeable on what action to take in the event of an allegation of abuse. Residents and visitors spoken with said that they felt safe in the centre. However, staff training on elder abuse was out of date as it had not taken place since 2012 and there were some staff who had not received elder abuse training in the centre.

The inspectors reviewed the systems in place to protect residents’ finances. A robust system was in place to document the payment of fees by residents and receipts for additional charges such as physiotherapy, hairdressing and chiropody were seen. The centre kept documentary evidence of money paid into and out of residents’ petty cash
funds. However, as required by Schedule 3(5)(b)(i) the purpose for which money was used was not always documented for each transaction where applicable. This was addressed under Outcome 5 Documentation.

The centre had an up to date policy on the management of behaviours that challenge. However, not all staff had training in behaviours that challenge in the centre in order to meet the needs of the residents. The inspectors reviewed a care plan of a resident who displayed behaviours that challenged. The care plan was in place for the management behaviours that challenged. However, inspectors noted that it was not detailed or person centred as it did not outline clearly the goals of care, the interventions suitable for this resident and the controls in place to reduce the incidence of these behaviours. While this resident was receiving multidisciplinary team (MDT) input, these recommendations were not updated in the care plan. The behaviour recording chart which staff showed inspectors appeared to be used inconsistently to monitor the behaviours. Staff spoken with were unsure as to contribution of these MDT reviews or the behaviour monitoring chart in terms of improving the resident’s quality of life.

Inspectors reviewed the documentation informing the use of bed rails in the centre. Consent forms signed by the general practitioner, nurse and relative were in place as well as a care plan for the use of bed rails. However, the practice in place in the centre regarding the documentation of the details of the restraint in use (timeframes, duration, monitoring of bed rail use) was not in line with the centres policy on restraint or with national policy. The restraint review and release charts which were required to be completed on a daily basis had not been completed over the previous 3 weeks for one resident. The policy in place for the use of restraint was dated 2015, however the old policy dated 2012 was also still place in the centre’s policies folder.

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 actions from the previous inspection were addressed and window restrictors were in place and the laundry had implemented a system to reduce the risk of cross contamination between dirty and clean laundry. The centre had an up to date Health and Safety statement in place.

Inspectors saw service records for fire equipment (fire extinguishers, fire blankets, fire
hoses, emergency lighting, fire doors). Daily and weekly checks of fire equipment and escape routes by staff were documented. The fire alarm system had recently been serviced (June 2015). Records of regular fire drills were seen, however there was inadequate detail recorded regarding the fire drill, for example the number of staff or residents involved in the evacuation or the evacuation time was not always recorded. Inspectors viewed the fire safety staff training records and found that some staff had not attended the mandatory fire safety training sessions. The centre did not have personal emergency evacuation plans in place for residents. Some fire doors were seen held open with door wedges. In addition, not all staff had up to date manual handling training.

The centre had a risk and hazard identification documents in place. However, the risk assessments and documented controls for the identified risks were inadequate and often were not centre specific. For example, under the risk of fire, the control strategy documented no smoking in any part of the building. However, inspectors were told by staff that one resident smoked in their bedroom. Inspectors were also informed that there was the additional risk to this arrangement in that an oxygen cylinder was also stored in this resident’s bedroom. In addition, this resident was not supervised when smoking and this residents’ smoking risk assessment had not been updated to reflect this unsafe arrangement. An immediate action plan was issued to the person participating in management in relation to this unsafe arrangement. The person participating in management took immediate action in relation to this issue. There was also a smoking room in the centre where cigarettes and ash were disposed of in an ashtray stored on a shelf. This arrangement posed a risk of fire if the ashtray fell from the shelf and the room contained flammable items such as books and soft furnishings. This room was also used as the centre’s shop storing confectionary and other toiletries which may have been flammable.

Other risks which had not been risk assessed or suitably controlled were found during the inspection. Linen stores containing plastic aprons, and other store rooms containing wheelchairs, were found to be open posing a risk of accidental injury to residents with a cognitive impairment. The hairdresser room, containing hairdryers and other heated hair equipment, was unsecured. Staff informed inspectors that sluice rooms and stores should be locked, however many were unsecured and the keys for many rooms were hanging on the door frames, or left in the key holes in the door and this practice had not been risk assessed. A kitchen located beside an activities room was open and contained a hot water boiler and cooker posing a potential risk of injury to residents with a cognitive impairment. In addition, a radiator on a corridor which was turned on during the day of the inspection was scalding in temperature and posed a burns risk to residents. This was brought to the immediate attention of staff.

The incident records were reviewed by inspectors and were found to contain details of each incident. However, the section to document the action taken and improvements implemented as a result of the incident was often not completed and were left blank. The inspectors were not assured that there was a robust system in place to review and learn from incidents which arose in the centre.

Concerns regarding infection control procedures were noted during the inspection. Areas of the laundry room, such as high windows and window ledges were seen to have dust
and cobwebs posing a risk of infection. Staff informed inspectors that these areas were not covered by the cleaning schedule. Visible dust was also found on bed frames, electrical casements, medication trolleys and radiators in the centre. Inspectors observed that staff did not engage in hand hygiene at all appropriate stages when caring for residents and working in the centre. Some of the hand sanitising gel dispensers in the centre were empty. Laundry trolleys were stored in sluice rooms posing a risk of cross contamination. Blue aprons which were worn by staff when serving meals were stored on the air dry racks for containers in the sluice rooms. A mop, which was not part of the colour coded mop system used by cleaners, was stored underneath an air dry rack in a sluice room. The ventilation fan in a toilet was visibly coated in dust. The sinks, and areas around the sinks, at the nurses’ stations were visibly dirty. Some waste bins in toilets were not foot pedal bins. One of the sluice rooms, which had a bed pan washer, did not have a stainless steel sluice sink for discarding waste. Staff informed inspectors that if the contents of commodes or bed pans needed to be emptied on this unit the container would be carried to the sluice room in the next unit. Inspectors formed the view that this practice posed a significant risk of infection in the units and were not assured that the sluicing practices in the centre were appropriate. A shower chair and commode chairs were inappropriately stored in sluice rooms. Unlocked presses storing chemical cleaning agents were in the sluice rooms, posing a risk to residents. Inspectors were informed by staff that the process for cleaning residents' en-suite bathrooms often started at the toilet and then continued to the rest of the room; this practice was not best practice and posed a risk of cross contamination.

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

Findings:
The residents' medications prescribed for regular use were supplied to the centre in monitored dosage systems (MDS) which had a printed description of the tablets contained in each pouch. The inspector reviewed a sample of the MDS and found that the contents matched the prescription for regular medications. The residents' PRN (as required) medications were not dispensed in an MDS system and were stored, with an attached pharmacy dispensing label, with the residents MDS in a box for each individual resident. However, when the inspectors reviewed a small sample of resident medication boxes, PRN (as required) medications were found in storage without an expiry date, and
sedative tablets were found in one residents medication box which were no longer prescribed for the resident. Some medications were stored on the medication trolley without a dispensing label to indicate who the product was dispensed for, including creams, inhalers and tablets. A fridge storing medications on one ward was found to be leaking water on the inside. Two boxes of residents' high-tech injection medications stored in this fridge for several months were visibly wet and potentially contaminated by the leak. Another medication fridge was found to be unsecured nutritional supplements were found in a store room in the centre which were out of date with 5 months. These findings were highlighted to the person participating in management by the inspector. The inspectors formed the view that the system for the storage of medications stored in the centre was inadequate.

A sample of medication prescription sheets was reviewed. A photograph of the resident, their date of birth and their allergy status were in place. However, the maximum daily dose of PRN (as required) medications was not always prescribed. Medications were found dispensed for residents with instructions on the label which did not match the prescription. For example, a resident was prescribed a regular and PRN (as required) dose of a painkiller on their prescription however, the regular dose of the medication was not dispensed in the MDS and the medication dispensing label had different instructions to that of both prescriptions. On another residents’ prescription, an anti-epileptic medication had not been discontinued when the dosage was increased on a faxed prescription attached to the file. Another resident had a faxed prescription with an attached note in place giving instructions to discontinue a prescribed sleeping medication and to replace it with the new medication on the faxed prescription. However, the faxed prescription and note had been in place for over a month before the inspection date. The inspectors found a medication error whereby both of these medications had been administered to the resident on at least two consecutive nights during the week previous to the inspection. The medication to be administered and the discontinued medication were both still being stored in the resident’s medication box. In general, the inspectors found that there was an over-reliance on faxed prescriptions in the centre which increased the risk of medication error and, as outlined above, had resulted in at least one medication error which was found on the day of inspection. The medical review of residents' medication every 3 months was inconsistently documented on residents' prescriptions with periods of up to 5 months seen between the review dates documented on one prescription. The inspectors discussed the seriousness of this situation with nursing staff and the person participating in management and highlighted that centre's practice around the use of faxed prescriptions was not in accordance with An Bord Altranais agus Cnámhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management 2007.

The system for recording the administration of medications on the medication administration record (MAR) was not adequate. The times of the medication rounds did not always correspond to the times pre-printed on the MAR sheet. Each medication on the residents’ prescription sheet was assigned a number and this number was then used on the MAR to indicate when it was administered. This system had the potential for medication error especially when faxed prescriptions were in place. The inspectors reviewed one prescription sheet, along with the MAR sheet, and a faxed prescription. When a new medication was added to the prescription sheet, the number assigned to
the medication on the faxed prescription was changed which led to confusion when trying to interpret the point at which this change occurred on the MAR sheet. The system for recording if a medication was not administered did not clearly outline or document whether a medication was refused by the resident or withheld by the nurse. A resident had received a course of intravenous antibiotics in the centre which were administered by a visiting nurse from the hospital. However, there was no prescription or record of administration for these antibiotics in the residents’ medical or nursing files. An action was given for these failings in the documentation of medications administered to residents under Outcome 5 Documentation.

The inspectors checked the balance of a small sample of controlled drugs in stock and found that the balance matched that documented in the controlled drugs administration register. The twice daily check of the balances of controlled drugs was conducted by two nurses at the start of each shift. However, this twice daily system was inadequate as the record did not itemise each controlled drug and the corresponding balance in stock.

The centre conducted regular audits of medication management. However, on consideration of the aforementioned issues found during this inspection the inspectors was not assured of the contribution of these audits towards improving practice. At the close of the inspection the inspectors highlighted to staff and the person participating in management the serious concerns they had regarding medication management and resident safety in the centre given the many issues identified in the small sample of medication prescriptions and dispensed medications reviewed.

**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:**
The centre kept copies of all notifications made to the Authority in the centre. Quarterly and three day notifications had been received by the Authority, as required by the Regulations.

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

Findings:
Inspectors viewed a sample of residents’ care plans, medical and nursing notes. Residents had a comprehensive assessment of their health and social care needs conducted on admission to the centre. There was evidence of visits from general practitioners and allied health care professionals (dieticians and speech and language therapists). Assessments of residents’ activities of daily living were updated every four months. Care plans were in place to guide the health and social care needs of residents. However, the care plans were generic in format and content and did not identify individual needs and choices. As the care plans had pre-printed interventions recorded, inspectors could not be assured of the contribution of care plans to guiding resident care or improving their individual quality of life. For example, the care plan of one resident who had been reviewed by the dietician for on-going weight loss was not up to date and did not outline the recommendations of the dietician which included specific guidance on nutritional supplements and maintaining a high calorie and high protein diet. A food recording chart was in place for this resident and staff recorded the content and quantity of meals eaten during the day. However, the food chart was not completed in the evening even though the dietician had recommended that this resident have a second evening supper. The issues around care plan documentation were also addressed under Outcome 5 Documentation.

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:
Overall, inspectors found that the centre was homely and well decorated throughout. There were 46 single bedrooms and 7 twin bedrooms which had en-suite bathrooms. However, there was a six-bed bedroom which was unsuitable to protect the privacy and dignity of the residents. This had an impact on residents as they were unable to undertake personal activities in private or to meet with visitors in their bedroom in a private area. This had also been a finding and action on the last inspection. Inspectors noted that building works were well advanced in relation to providing alternative bedroom accommodation to this six-bed bedroom.
The centre had three sluice rooms fitted with bed pan washers. However, one sluice room did not have a suitable sluicing sink in place. The arrangement for the storage of containers and the position of the air dry rack for containers in this sluice room were also inadequate. While there appeared to be storage space and rooms in the centre, some wheelchairs, commodes and shower chairs were seen inappropriately stored in sluice rooms. The laundry in the centre was adequate and since the last inspection a hand wash sink had been put in place.

Judgment:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:
The centre had a complaints procedure that was adequately displayed for residents and visitors attention in the main reception. There was evidence that all complaints were recorded in the complaints log with details of the complaint, the investigations and the solutions recorded. However, it was not always recorded whether or not the complainant was satisfied, as required by Regulation 34(1)(f). Also, it was not clear from the complaints log whether measures required for improvement were implemented as a result of complaints.

Judgment:
Non Compliant - Moderate
**Outcome 16: Residents' Rights, Dignity and Consultation**

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

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

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

**Findings:**
This outcome was addressed in so far as it pertains to residents' privacy and dignity in the centre.
Folders of nurses' daily notes outlining resident care and welfare, and residents’ bowel management charts were seen unsecured and unattended on a nurses’ station which posed a risk to residents’ privacy and protection of confidential information.
Many toilets and shower rooms doors did not have door locks on the inside to facilitate resident privacy.
CCTV cameras were in place at the front and rear entrance to the centre as well as four CCTV cameras on bedroom corridors. There was inadequate signage in place to notify residents and visitors that internal CCTV was recording in the centre. The centre had a policy on the use of CCTV which outlined that the CCTV cameras were recording as a security measure. However, inspectors formed the view that these internal CCTV cameras that recorded activities in residents’ bedroom corridors compromised residents’ privacy and dignity.

**Judgment:**
Non Compliant - Moderate

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**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

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

Findings:
There was an actual and planned staff roster in place and on the day of inspection staff numbers were on duty as outlined on the roster. Inspectors were satisfied that there was twenty-four nurse on duty in the centre to meet the needs of the residents. Nurses’ registration numbers with An Bord Altranais agus Cnáimhseachais na hÉireann were up to date and many healthcare attendants had FETAC level 5 training. The person participating in management informed inspectors that staff performance appraisals were conducted annually by the person in charge.

Staff training records were viewed by inspectors. However, not all staff had up to date training in manual handling, behaviours that challenge and fire safety. The last elder abuse training in the centre was out of date as it was last held in 2012. The inspectors viewed a sample of staff files and, as outlined under Outcome 5 Documentation, there were some gaps in the requirements of Schedule 2 of the Regulations. Inspectors were also concerned that there was inadequate supervision in place resulting in an unsafe practice in place when all staff attended morning handover and left wards unattended. This issue was also addressed under Outcome 2 Governance and Management.

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:

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

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<tr>
<th>Centre name:</th>
<th>Our Lady of Fatima Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000264</td>
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<tr>
<td>Date of inspection:</td>
<td>21/07/2015</td>
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<td>Date of response:</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:
At the weekend and at night-time it was unclear who was the accountable person, this person was not named or identified for each shift.

1. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
The Person in Charge at Weekends, Holidays and Night Duty is clearly identified on schedule.

Proposed Timescale: 27/07/2015

Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care and the quality of life of residents in the centre.

2. 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:
Conducted resident surveys on activities, food preferences, discussion groups on residents’ concerns as well as getting feedback from residents at council meetings that addressed quality of life and safety of care. All of the results are documented in separate folders but have not been coordinated and consolidated into one document to give the ‘big picture’ and the overall result.
In addition we are presently conducting surveys involving residents and families requesting their input regarding quality of life, including aspects of safety and overall quality of daily living at the home.
Plan to consolidate all this information into a final report by September 30th

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:
A copy of the most recent Statement of Purpose was not available in the centre.

The documentation of medication administration in the centre was not in accordance with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management 2007.
Where detailed recommendations had been made by the dietician regarding a resident who was losing weight, this information had not been updated on his current food and nutrition care plan. This system of recording was not in line with best practice as set out in *An Bord Altranais agus Cnáimhseachais na hÉireann* "Recording Clinical Practice Guidance for Nurses and Midwives".

Not all staff had outlined a full employment history and a vetting disclosure from an Garda Síochána was not in place for a new member of staff.

As required by Schedule 3(5)(b)(i) the purpose for which residents’ money was withdrawn and used was not always documented for each transaction where applicable.

3. 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:

Statement of Purpose
The most recent Statement of Purpose is dated and available and posted at Reception and all Nursing Stations. Previous Statements of Purpose have been removed and discarded from system. This was already implemented on 14/08/2015

Medication Management
In the short term policies and procedures around medication management are being reviewed. With this will come the introduction a new medication Kardex similar to the Abbey System which will clearly identify with images the medicines prescribed with times for administration. There will also be an area where nurses can document if a medication has not been given or taken and the reason why.

Regular 3 monthly multidisciplinary discussions will be set up to review medications, Kardex will be updated and faxed prescriptions will only be valid for a period of 72 (seventy two) hours. Training on medication management will take place for all nurses starting September 1st 2015 and will run weekly until all nurses have been updated. Twice daily monitoring of medications that are stored in fridges. (two of the medications fridges have been replaced)

Daily monitoring, checking on ordering and storage of all medications.
Weekly audits will be carried out initially, to ensure that we are complying with new system and will allow us to identify any problem areas and take necessary action.

Monthly audits will be carried out which will include the monitoring of the ordering, storage and administration of medications to ensure that our new system is being adhered.

Special emphasis will be on ensuring that we are following our policy on faxes. Our medication audit tool will be revised so that it is more robust enabling us to learn from any deficiencies and nurses will be oriented into carrying out these audits.
Our pharmacist has agreed to work with nurses in the implementation and ongoing auditing of new system. There will be ongoing interactive sessions with nurses and pharmacist
Timeline  approx. Sept 22nd 2015

In the longer term further improvements around medication management will be introduced with the introduction of eMAR along with ongoing training for all nurses and caregivers. No timeline for this long term improvement: under review at present by our pharmacist.

Nutrition
The nutritional supplement had been updated on the problem identification sheet on 20/5/15 and the dietician recommendations had been implemented. (The nutrition care plan is used only as a base line on admission). Dietician also recommended an additional meal at 7pm to break the fast from 4pm supper. This was recorded on 2 out of 3 food charts in his file. The meal was given at a time that was most suitable for the resident which settled him for the night, i.e. 20.00HR – 21.00HR. The dietician had further reviewed this resident on 16/7/2015 and this had not been updated on chart.
Staff are currently reviewing our process with a view to combining our Nutrition Care Plan into one which will be 'The Nutrition and Weight Management Care Plan' so that all the information will be recorded in one area, i.e. Weight, MUST Score, Swallowing Assessment and Nutrition Plan. (At present Nutrition Care Plan records Weight and MUST Score and is used as a baseline only)
Timeframe November 1st 2015

Staff Files
All staff files will be reviewed and any gaps in employment history will be corrected. One member of staff who had worked with the HSE for 39 years and has robust references from there was awaiting the return of Garda vetting which had been submitted to NHI Garda Vetting Unit at the time of hiring. Satisfactory Garda Vetting obtained for this employee on 21/8/2015 Timeframe for completion to review all employee files. 30th August 2015

Residents Money.
We have a strict policy and protocol on control of resident’s money. Monies in the safe are signed in and out and always checked by two people. If items purchased from outside, a receipt is placed in residents file. This is signed off by the person who purchased the supplies. We have now introduced a system where a second person or the resident themselves countersigns purchases and receipt placed in residents file. Introduced on 27th July 2017

Residents will sometimes purchase items of toiletries and soft drinks from our mobile shop which is basically a service offered for the convenience of our residents, i.e. Seven Up, Soft Drinks and Toiletries. Although the cost of the items was recorded it did not specifically say what was supplied to the resident.

We now document items that was supplied by shop and record maintained. This has already been corrected on 27th July 2015.
Sometimes residents who are fully competent to make their own decisions request some pocket money from the safe (if they have petty cash stored in safe). This usually is the region of €20–€30. We believe that we should not question the resident what they need the money for as it is their money and we must respect their privacy unless for some reason we suspect that there is some financial abuse going on.

**Proposed Timescale:** 01/11/2015

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff had training in behaviours that challenge in the centre in order to meet the needs of the residents.

The care plan in place for the management of a residents behaviours that challenge was not detailed or person centred as it did not outline clearly the goals of care, the interventions suitable for this resident and the controls in place to reduce the incidence of these behaviours. Staff were unsure as to contribution of the MDT reviews or the behaviour monitoring chart in terms of improving the residents quality of life.

**4. 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:**
Behaviour Management Care Plan. The care plan for the resident with challenging behaviour was personalised and clearly outlined the interventions suitable for this resident to reduce or modify the occurrence of such behaviour. The behaviour monitoring chart was used only when an outburst occurred and this chart was utilised by the MDT at each visit to get overall picture of his behaviour since last visit.

**Staff Training**
Majority of staff have had up to date training on behaviours that challenge and those who through illness, holiday, maternity leave etc. that have yet to attend, will receive training by year end. A catch up class is usually held for such classes by year end.

**Proposed Timescale:** Complete staff training on behaviour that challenges by Nov 30th 2015
Proposed Timescale: 30/11/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The practice in place in the centre regarding the documentation of the details of the restraint in use (timeframes, duration, monitoring of bed rail use) was not in line with the centres policy on restraint or with national policy.
The restraint review and release charts which were required to completed on a daily basis had not been completed over the previous 3 weeks.
The policy in place for the use of restraint was dated 2015, however the old policy dated 2012 was still place in the policies folder.

5. 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:
All Schedule 5 policies have been thoroughly reviewed and revised over the last 6 months. Unfortunately the old policy on restraints dated 2012 had not been removed from system. This has now been rectified, all old policies have been removed on 22/7/2015

The restraint review and release charts have been implemented and updated in line with policy. 19/8/2015

Proposed Timescale: 19/08/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff training on elder abuse was out of date as it had not taken place since 2012 and there were some staff who had not received elder abuse training in the centre.

6. Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

Please state the actions you have taken or are planning to take:
All staff at the centre had undergone Elder Abuse Training since employment and has been repeated, last done 2012. However, Elder Abuse had been addressed in great detail at dementia training and challenging behaviour training which took place this year when the majority of staff received 8 hours of interactive training that included scenarios so that staff could identify what could be classed as abuse. In addition two
senior nurses had attended elder abuse training in Cork and plans were already in place to roll out elder abuse training in September this year.

Proposed Timescale: Dates have now been set and Elder Abuse Training will commence on Sept 1st 2015 and will run weekly for a period of 6 weeks and rolled out to all staff.

**Proposed Timescale:** 11/12/2015

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

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
As outlined in the body of the report, many storage rooms and sluice rooms in the centre were unsecured on the day of inspection posing risks of accidental injury to residents.

7. **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:**
Locks have been placed in all storage/sluice rooms and cupboards and staff will be reminded to ensure rooms are locked for resident’s safety.

Hazard Identification Sheet as outlined in our Risk Management Policy will be implemented (instead of CAR sheet) at once and will replace the CAR Sheet which we were completing.

**Proposed Timescale:** 17/08/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was an inadequate system in place to learn from serious incidents or adverse events involving residents.

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

Hazard Identification Sheet as outlined in our Risk Management Policy will be implemented (instead of CAR sheet) at once and will replace the CAR Sheet which we were completing.

Other hazards as identified in the body of the report are being actively worked on i.e. smoke room, (all flammable books, toiletries and confectionary have been removed and new ventilation system installed), Fire Buckets filled with SAND have been implemented to dispose of cigarette butts.

The hairdressing room (this will be locked and secured at all times when hairdresser is not present)

All uncovered radiators will be covered. Radiator covers are on order.

In the meantime radiators have been fitted with regulators to ensure that they are too hot.

Smoking policy is strictly adhered to and smoking is only allowed in resident’s smoking room.

In addition our Health and Safety Audit has been revised so that we will learn from incidences that will be documented in Hazard ID Sheets.

Proposed Timescale: 31/08/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
As listed in detail in the body of the report, the inspection found that the centre had inadequate infection prevention and control measures in place.

9. 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:
Infection Control.

Infection control concerns highlighted in the body of the report are being addressed at present. Due to the infrastructure, the sluice room without a sluice sink cannot be corrected until we are transferred to the new building which is due to take place in October 2015. A definite date has yet to be announced.

Infection control training will be rolled out to all staff, commencing in September. This will be ongoing for several weeks.

Hand hygiene audits and training will commence September 2015 and will be ongoing. SEPTEMBER 30TH 2015

The process for room cleaning has been revised with all housekeeping staff: starting with high dusting, then furniture cleaning, then the bedroom and finally bathrooms. Colour coded mops and dusters are in place for cleaning. Long reach dusters have been
provided so that dust and cobwebs can be removed from hard to reach places. Cleaning will include cleaning of bedframes, electrical casements, and radiators. Nurses will ensure medication trolleys are cleaned. Daily checks are made to ensure hand hygiene sanitizers are filled and functioning.

Blue Aprons have been removed from sluice room (these should never have been put there as this is not our practice). Mops that are not colour coded have been removed and replaced with colour coded red and blue mop heads for any mopping after hours. We have drawn up a cleaning program and all fans in bathrooms will be deep cleaned. Cleaning will start on September 1st and will be completed by September 18TH 2015.

Sinks and surrounding areas at nurses’ stations have been thoroughly cleaned.

Bins in toilets have been replaced by foot pedal bins on 24/8/2015

Random weekly checks and audits will be carried out to ensure that employees are following correct protocols and feedback to employees will be provided straight away.

Due to the infrastructure, the sluice room without a sluice sink cannot be corrected until we are transferred to the new building which is due to take place in October 2015. Locks have been placed in all storage rooms and cupboards and staff will be reminded to ensure rooms are locked for resident’s safety. Staff will carry keys to gain access to these areas. Shower chairs and commode chairs have been removed from sluice area, only dirty laundry is stored in sluice rooms.

| Proposed Timescale: | 31/10/2015 |
| Theme: | Safe care and support |

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date fire safety training.

10. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Fire training takes place annually and continues to roll out throughout the year. Many of our staff who have been employed for several years have undergone regular annual training. We already had three fire training sessions and drills this year and two more are planned for October. The schedule is designed to work in line with our staff rosters.
and catch all staff so that they have attended at least one training session. A catch up class will be held at year end if there are any staff members yet to attend.

Proposed Timescale: Ongoing and will be completed by October 2015

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centre did not have personal emergency evacuation plans in place for residents.

**11. Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**
Personal evacuation plans for residents has been drafted and is presently being piloted. It is expected to have PEPs in place for all residents by October 1st 2015.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The centres practices around resident smoking in the centre did not adequately prevent against the risk of fire. The smoking room in the centre was not adequately equipped with a suitable bin for the disposal of cigarettes and ash, and flammable materials were kept in the smoking room. Some fire doors were seen held open with door wedges.

**12. 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:**
The resident's smoking room has been revamped. A new ventilation system has been installed. All flammable materials have been removed and suitable fire buckets with sand have been put in place for the disposal of cigarette ash have been put in place as of 21st August 2015. All door wedges will be removed from use. All firefighting equipment had been
Outcome 09: Medication Management

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
As outlined in detail in the report, the system to ensure that medications were stored securely and appropriately in the centre was inadequate.

**13. 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:**
Medication Management – Storage
Medication Management system will be totally revised which will address storage of medications. Our pharmacist has reviewed our present system and together with nurses and physicians has outlined plans to update our system to reduce the risk of medication error. Adequate storage and disposal of medications is being corrected. New Drug Fridges are being installed and a daily rolling control drugs register will be implemented. In addition our medication audit tool will be revised to address areas of deficiency outlined in the body of the report. Training in the new system will be given to all nurses starting September 1st 2015

Proposed Timescale: 21/09/2015

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
As outlined in detail in the report, there were several failings regarding the administration of medications in accordance with the directions of the prescriber.

**14. 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:**
Administration of Medication
Faxes will be strictly used for 72 (Seventy Two) hours only and then GP must write up medications. The IV antibiotic nurse will provide copy of prescription and her record of administration. A copy of this will be placed in the residents file. Physicians will be notified to review and update Kardex at three monthly intervals or as required. This will be documented

**Proposed Timescale:** 21/09/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
As outlined in detail in the report the system to ensure that medications no longer required, no longer prescribed or expired were segregated from and disposed of safely was inadequate.

**15. Action Required:**
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

**Please state the actions you have taken or are planning to take:**
Medications
Medication that have been discontinued or no longer required will be removed immediately and medication disposal container has been provided by pharmacy and used for safe disposal of unused/unwanted medications. This medication container is kept in a locked cupboard at nurses station and was implemented on 17/8/2015 A red dot system will be implemented to alert nurses of expiratory dates of PRN and other medications.

**Proposed Timescale:** 22/09/2015

**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 care plans were generic in format and content and did not identify individual needs and choices. As the care plans in place had pre-printed interventions recorded, inspectors could not be assured of the contribution of care plans to guiding resident care or improving their individual quality of life.
16. **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:
Care Plans.
Although our care plans are pre-printed, all care plans are personalised for each resident to allow free text (we would invite inspectors to look at a number of care plans so we can explain our personalised care plan system). Our screening assessments – 4 monthly or as required – and ADL sheets reflect resident’s current requirements and are used to guide their care or to improve their quality of life. However we will continue to review our care plans and ensure and make any adjustments that we feel will improve the personalisation of all care plans.

Training sessions will commence on the 1st Sept 2015 to all RGN’s to update and refresh them on personalised care planning.

Proposed Timescale: Commence Sept 1 and will continue for the month of September 2015

Proposed Timescale: 30/09/2015

**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 six-bed multi-occupancy bedroom did not afford residents with privacy and dignity.

17. **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:
6 bedded Multi-Occupancy Unit

We fully agree that the six bedded multi occupancy room does not afford the privacy and dignity that we would like to provide for our residents. However we are very advanced in our new building to replace our multi occupancy room. This should be ready for occupancy October 2015. As yet, the building contractor has not provided us with an exact ready to move in date.
**Proposed Timescale: 31/10/2015**

### Outcome 13: Complaints procedures

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
It was not clear from the complaints log whether measures required for improvement were implemented as a result of complaints.

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

**Please state the actions you have taken or are planning to take:**  
Complaints  
Complaints are tracked and any trends noticed are addressed at staff meetings and at hand over reports to implement improvements.

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

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
It was not always recorded whether or not the complainant was satisfied.

19. **Action Required:**  
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**  
Complaints  
All complaints are dealt with as soon as possible and any improvement required are implemented, however our documentation may not demonstrate that the resident is satisfied with the outcome. Our complaints log will be modified to reflect the outcomes. If a resident is not satisfied with the outcome of the complaint, it is referred to the DON, or to our advocacy representative who visits the home regularly and also chairs the resident’s council meeting which are held quarterly.
### Proposed Timescale: 25/08/2015

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

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Folders containing nurses daily notes outlining resident care and welfare, and residents bowel management charts, were seen unsecured and unattended on a nurses station which posed a risk to residents privacy and protection of confidential information.

**20. Action Required:**
Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

**Please state the actions you have taken or are planning to take:**
All records pertaining to residents will be stored in a secured place at the nursing station and not left unattended. This will be monitored on an ongoing basis.

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### Proposed Timescale: 16/08/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Many toilets and shower rooms doors did not have locks on the inside to facilitate resident privacy. The internal CCTV cameras compromised residents’ privacy and dignity.

**21. Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
Toilets/CCTV
Wheelchair toilets will be provided with locks to facilitate resident privacy.
Locks for toilets and shower doors in residents’ room are on order.

Our timeline is based on delivery of locks which has been given as 3 weeks. Our timeframe to have locks installed on all bathroom/shower doors will be completed by October 30th 2015

CCTV cameras which monitor the entrance and exit doors is only used for resident’s security. It does not affect their bedrooms in any way. With the layout of our large building, monitoring our entrances and exits is vital for resident and staff security. Signs have been posted on all exits door to inform residents, visitors and staff that the
exit doors are monitored by CCTV. Cameras have been adjusted so that only the emergency exit doors are visible on screen. Completed 24/8/2015

Proposed Timescale: CCTV cameras have been adjusted so that only the emergency exit door is visible on screen. CCTV notices posted on all emergency exit doors were implemented 24/8/2015

Proposed Timescale: 24/08/2015

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had up to date training in manual handling, behaviours that challenge and fire safety. Elder abuse training in the centre had been conducted more than 2 years ago.

22. 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:
Manual and patient handling
This has been completed by all members of staff and had been at time of inspection. Our log may not have reflected that. Upon checking employee files all employees have current manual & patient certification.

Behaviour that Challenge
We are aware that we have a number of nurses and HCA’s who have yet to attend challenging behaviour as they were not available due to illness, vacation/maternity leave at the times of courses. However it is planned that we will run this course again this year to do a catch up on those staff that did not attend.

To be completed by Nov 30th 2015

Fire training
Fire training takes place annually and continues to roll out throughout the year. Many of our staff who have been employed for several years have undergone regular annual training. We already had three fire training sessions and drills this year and two more are planned for October. The schedule is designed to work in line with our staff rosters and catch all staff so that they have attended at least one training session. A catch up class will be held at year end if there are any staff members yet to attend.

To be completed by Nov 30th 2015
Elder Abuse
All staff at the centre had undergone Elder Abuse Training since employment and has been repeated, last done 2012. However, Elder Abuse had been addressed in great detail at dementia training and challenging behaviour training which took place this year when the majority of staff received 8 hours of interactive training that included scenarios so that staff could identify what could be classed as abuse. In addition two senior nurses had attended elder abuse training in Cork and plans were already in place to roll out elder abuse training in September. Dates have now been set and Elder Abuse Training will commence on Sept 1st 2015 and will run weekly for a period of 6 weeks and rolled out to all staff.

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

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were also concerned that there was inadequate supervision in place resulting in an unsafe practice in place when all staff attended morning handover and left wards unattended.

23. **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:**
Inspectors were also concerned that there was inadequate supervision in place resulting in an unsafe practice in place when all staff attended morning handover and left wards unattended.

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:
Three members of staff (care assistants) remain on floor during handover. This was implemented 24/8/2015 and will be revised to ensure that residents are kept safe. The other nurses and care assistants receive hand over report and the nurses at each station give a handover report to the care assistant that remained on floor during handover.

**Proposed Timescale:** 24/08/2015