Centre name: St. Louis Nursing Home
Centre ID: OSV-0000289
Centre address: Clonmore, Tralee, Kerry.
Telephone number: 066 712 1891
Email address: nhstlouis@eircom.net
Type of centre: A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider: Yvonne Maher
Provider Nominee: Yvonne Maher
Lead inspector: Aoife Fleming
Support inspector(s): Vincent Kearns; Liam Strahan
Type of inspection: Announced
Number of residents on the date of inspection: 24
Number of vacancies on the date of inspection: 1
About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: 23 June 2015 09:15  
To: 23 June 2015 18:00  
From: 24 June 2015 09:00  
To: 24 June 2015 15:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</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>Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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Summary of findings from this inspection

The inspection was an announced renewal of registration inspection and took place over two days and was the ninth inspection of the centre by the Authority. As part of the inspection process, the inspectors met with the provider, the person in charge, residents, relatives, visitors and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, incident logs,
policies and procedures, risk management documentation and staff records. The documentation reviewed also included questionnaires completed by residents and relatives and the feedback was positive overall.

The findings of the inspection are set out under 18 outcome statements. These outcomes are based on the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. There was evidence of the residents medical and social needs being met and residents were supported by staff to maintain their independence where possible. However, improvements were required in the areas of risk management, medication management, health care and end of life care documentation, premises and storage of residents' personal property. There were significant concerns regarding the documentation of medications in the centre (see Outcome 9 Medication Management). These issues were brought to the attention of the provider and person in charge on day two of the inspection and an immediate action plan was issued. The matter was investigated and the action plan was responded to in a timely and comprehensive manner. The provider's response indicated that immediate steps were taken to ensure safer systems were put in place.
### Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Statement of Purpose

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose was up to date and available in the centre. However, it did not include all the items required by Schedule 1 of the Regulations;
- a description of all rooms and their size and primary function was not provided
- the list of facilities was not up to date, for example it did not list the hairdressing room or visitors room in the centre.

** Judgment:**
Non Compliant - Moderate

### 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 clear management structure with staff reporting to the person in charge, a clinical nurse manager, who reported to the provider. However, the person participating in management was on leave and had not been replaced which was acknowledged by the person in charge and the provider as being an extra demand on
their time.
Audits were regularly conducted in the centre in the following areas; medication management, rights of residents, protection and admissions. The centre collected weekly information on the quality of care by recording the incidence of pressure sores, restraint, behaviours that challenge, pain and catheter usage. However, there was no annual review of the quality of safety and care in the centre as required by Regulation 23. It was not always evident from the audits conducted what learning or improvements to the service were made.

Judgment:
Non Compliant - Moderate

<table>
<thead>
<tr>
<th>Outcome 03: Information for residents</th>
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<tbody>
<tr>
<td><strong>A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.</strong></td>
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</tbody>
</table>

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspectors reviewed the residents' contracts of care and found that they listed the services provided by the centre, the fees charged and details of support from the nursing home support scheme. However, additional fees such as for hairdressing, chiropody and toiletries were not set out in the contract. The residents' guide was available to residents and visitors in the centre and clearly set out the services and facilities provided in the centre.

Judgment:
Substantially Compliant

<table>
<thead>
<tr>
<th>Outcome 04: Suitable Person in Charge</th>
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<tbody>
<tr>
<td><strong>The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.</strong></td>
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</table>

**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 involved in the day to day running and management of the
centre and was appointed to this role in September 2013. She was a clinical nurse manager and was well known to residents and visitors who spoke very positively about her. The person in charge was actively involved in conducting audits and overseeing the general management of staff nurses and health care assistant duties in the centre.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspectors reviewed documentation in the centre.

A sample of staff files were reviewed however, not all met the requirements of Schedule 2 of the Regulations. Not all files had a full employment history or two written references from previous employers or a Garda Síochána vetting form in place. This had also been a finding on the last inspection.

There was a directory of residents in place in the centre which met the requirements of Regulation 19. Copies of previous inspection reports was available in the centre. The person in charge maintained a copy of all notifications submitted to the Authority. A restraint register was maintained in the centre.

The centre had up to date policies in place as required by Schedule 5 of the Regulations. However, the fire policy did not reflect practice in the centre, for example it noted that the fire doors would open when the fire alarm sounded, however this was not the case as external doors had to be manually opened by staff.

The inspectors viewed a sample of care plans. While there was evidence of detailed daily notes recorded by nursing staff, the notes were dated and recorded as a day time or night time note without recording the actual time. There were gaps in care planning documentation and these was outlined under Outcome 11 Health and Social Care needs.
The inspectors were not reassured that a record of each drug and medicine was maintained at the centre and an immediate action plan was issued regarding this under Outcome 9 Medication Management.

**Judgment:**
Substantially Compliant

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

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

**Theme:**
Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The nominated person participating in management had been on leave for several months prior to the inspection and had not been replaced. Inspectors spoke with the person in charge and the provider about this and there was no arrangement in place to cover for the person in charge should she be absent for 28 days or more.

**Judgment:**
Non Compliant - Major

### Outcome 07: Safeguarding and Safety

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

**Theme:**
Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

A register of residents using bed rails was in place. There was an up to date policy guiding the use of restraint in the centre. The inspectors reviewed a sample of bed rail assessment forms. While new forms had been introduced, in some residents files the old forms were still in place. The bed rail review and release forms indicated that this check was conducted every 2 hours, however the assessment did not indicate whether or not this was suitable for all residents, for example if a resident was unwell. Signed consent
forms for the use of bed rails were seen.

All staff had up to date training in elder abuse and staff spoken with were up to date on the reporting procedures in place should an allegation arise. However, not all staff were trained in behaviours that challenge. This was outlined as a requirement for all staff in the policy on restraint and there were residents who had presented with behaviours that challenge in the centre.

Inspectors reviewed the systems for managing residents' finances. The centre did not hold finances for residents and inspectors were told that any additional fees were paid by families or relatives as they arose. Invoices for chiropody and hairdressing services were seen and corresponding invoices were available on file.

**Judgment:**
Substantially Compliant

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

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

**Theme:**
Safe care and support

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

**Findings:**
The centre had an up to date health and safety statement. However, elements of the health and safety policy did not reflect practice in the centre. The policy made reference to the sluice machine, of which there was none in the centre. The policy also noted the requirement for the appropriate use of personal protective equipment (PPE) in the centre. However, inspectors noted staff did not wear adequate PPE when manually emptying commode containers in the sluice room. This practice posed a significant risk of cross contamination in the centre. Inspectors noted that there were inappropriate sluicing facilities as the sluice room did not have a bed pan washer or sluice machine. A sink of water and a cleaning agent was filled every day and not replaced for 12 hours and this was used to soak commode containers throughout the day. The manufacturers guidance for this product did not indicate that this was appropriate practice posing a risk that commode containers and urinals were not properly disinfected in between use.

The risk register was reviewed by inspectors and was found to contain detailed risk assessments for individual residents with controls listed. However, the risks to staff and visitors and general environmental risks in the centre were not outlined in the risk register but were listed in other documentation such as the risk policy. The risk management policy also noted that a weekly hazard inspection of the centre was conducted, however evidence of this was not seen by inspectors. For the purposes of on-going centre-specific risk assessment in the centre and to ensure that this process
was conducted on a regular basis, these risks were required to be reviewed as part of the risk register.
The risk management policy did address the measures in place to control for abuse, self-harm, accidental injury, unexplained absence and aggression and violence.

The action in relation the storage of latex gloves from the previous inspection was not sufficiently implemented as latex gloves were stored, unsecured in presses, in shower rooms and in some residents' ensuite bathrooms.
Other risks identified in the centre which had not been risk assessed were;
- shaving foam was stored in unsecured presses in the shower rooms
- trailing wires were present in many residents' bedrooms posing a risk of trips and falls
- not all showers had shower hand/grab rails in place to assist residents
- deep drains in the enclosed garden areas posed a risk of trips and falls
- some resident bedside table tops were scuffed and worn and a deep clean could not be assured
- one bed had a rusty frame and flaking paint posing a risk of infection as it could not be deep cleaned
- oxygen cylinders being used by a resident and stored in their bedroom were not appropriately identified as a fire hazard
- one external door had a key hanging on the door frame which was not risk assessed and posed a risk to residents
- several windows were unrestricted when open and had not been risk assessed
- the enclosed garden areas had not been risk assessed.

Inspectors also reviewed moving and handling practices. On one occasion a lifting harness was used to assist a resident from a chair to a transport chair, however on another occasion staff used no lifting harness to perform the same transfer for the same resident. It was evident from staff practice that not all staff had been appropriately trained, and inconsistent practice was in place for resident moving and handling. This was addressed under Outcome 18 Staffing.

The fire evacuation procedure was displayed in the centre. Records of regular fire drills were maintained and staff spoken with were familiar with the evacuation procedures and had been trained in the use of the evacuation mats present in the centre. However, not all residents had a personal emergency evacuation plan in place which was particularly important as many residents were not fully mobile and not all beds could be easily evacuated out of bedrooms. Records of quarterly fire alarm testing were seen, fire safety equipment was serviced annually and appropriate daily, weekly and monthly checks of the fire alarm system, fire equipment and means of escape were conducted. However, the last service of the emergency lighting systems seen by inspectors was March 2012. The fire policy did not reflect practice in the centre, for example it noted that the fire doors would open when the fire alarm sounded, however this was not the case as external doors had to be manually opened by staff. This was addressed under Outcome 5 Documentation.

The centre had an up date emergency plan which clearly outlined the response to emergencies and identified an off-site evacuation location.

**Judgment:**
**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 inspectors reviewed the storage of medications in the centre. Regular prescribed medication was supplied to the centre in monitored dosage systems individually labelled for residents. The medication trolleys were locked and stored in a locked area of the centre.

The inspectors were not assured that the system for reviewing the expiry dates or storage of stock was robust as there was a large quantity of nutritional supplements stored in a press which the person in charge acknowledged were not all required at that time. Some supplements were due to expire within two weeks after the inspection, however, there was no system in place to review and remove these items for disposal. An action regarding this issue had been issued on the last inspection. Eye-drops which were in use did not have the opening date recorded on the bottle.

The inspectors reviewed the register of controlled drugs and saw that the balances of controlled drugs were checked twice daily at the start of each shift by two nurses. A random spot check of controlled drug balances found that these corresponded to the documented balances. A daily record of the medication fridge was maintained.

Residents had a choice of general practitioner and of pharmacist. A sample of medication prescription and administration sheets were reviewed by inspectors. Since the last inspection, a photograph of each resident was added to each prescription sheet. Residents allergy status was recorded and prescriptions were legible and reviewed on at least a 3-monthly basis. However, not all maximum daily doses of PRN (as required) medications were prescribed. In another case a resident was prescribed two oral paracetamol containing medications for PRN (as required) use, with the cumulative prescribed dose far exceeding the maximum daily dosage of 4g. This was highlighted to the person in charge and the general practitioner reviewed the prescription and discontinued one of the prescriptions. Results from a recent medication prescription audit (10 June 2015) indicated that this issue had previously been identified, whereby a resident was prescribed two PRN (as required) paracetamol medications, however appropriate action after the audit had not been taken to prevent this occurring again.

The PRN (as required) antipsychotic and sedative medications in stock were not dispensed in monitored dosage systems. When the inspector reviewed the balance of...
two residents diazepam dispensed supply, there was a lack of documentation to account for the administration of a significant number of tablets with large shortfalls existing between the stock and what had been administered to the residents. Where medications were missing from the stock balance many were not accounted for in residents’ medication administration sheets or in records of medications returned to the pharmacy which were viewed on the day of inspection. An immediate action plan was issued regarding this as documentation to adequately support the administration of PRN (as required) medication was not in place and the inspectors was concerned about the oversight of the PRN (as required) medication administration and documentation system. At the close of inspection management were not able to account for when or to whom these medications were administered to.

Judgment:
Non Compliant - Major

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
The centre had a copy of all notifications submitted to the Authority and quarterly notifications and notifiable events had been notified within the required time frames.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
There was evidence in residents' medical notes of regular and timely general practitioner visits to address their medical needs, with full medical reviews being conducted at least every 3 months. Documentation and follow up by staff of residents' out-patient or specialist appointments external to the centre were maintained.

The inspectors reviewed a sample of resident care plans. Residents' needs were assessed in terms of mobility, falls risk and any relevant health needs. However, in general inspectors found that care plans were not fully reviewed every 4 months to update the interventions in place. For example, a hypertension care plan for a resident had last been updated in May 2014, and on review of the evaluation entries it was unclear whether the resident now had hypotension or hypertension.

Residents had access to occupational therapy, physiotherapy, speech and language therapy and a dietician by referral and evidence of visits was seen in the residents' notes. However, the incorporation of the recommendations of these allied health professionals into residents' care plans was not consistent. A speech and language review for a resident in 2012 had recommended a specific texture diet and grade of fluid, however this was not documented in the residents nutrition and oral hydration care plan in 2014. This was addressed in Outcome 15 Food and Nutrition as well. The interventions in a mobility care plan had not been updated to include recent recommendations from the occupational therapist and physiotherapist. This system of recording care and health conditions was not line with the guidelines as set out by An Bord Altranais "Recording Clinical Practice Guidance for Nurses and Midwives" 2002.

Some residents had an assessment form ('A key to me') in their file to assess their social needs, however this was not completed for all residents.

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:
Since the last inspection a call bell was placed in the visitors room. Some of the actions
identified on the last inspection were not implemented:
- not all residents had adequate storage space as one resident's wardrobe space was inadequate
- signage in the centre did not identify the hairdressing room or the visitors room appropriately
- not all showers had been fitted with grab hand rails.

The centre was not compliant with the requirements of Schedule 6 of the Regulations in the following regard;
- overall the centre required painting throughout as there was paint flaking from some walls and there were many scuff marks on the walls, door frames and skirting boards, giving the centre an unmaintained appearance
- the laundry storage room had damp coming through the walls, plaster was bubbling and paint was flaking off the walls
- there was no assisted bath in the centre
- the centre had inadequate sluicing facilities as there was no bedpan washer or sluice machine
- there was inadequate ventilation in residents' en-suite bathrooms and in a communal toilet
- one resident's en-suite bathroom was very dark even with the light on and had a faulty toilet
- there were no locks on the bedroom doors or on the doors of residents' en-suite bathrooms to ensure privacy
- there were no televisions in several bedrooms
- one two-bedded bedroom in particular was not decorated or personalised in a homely manner and was very dark
- not all residents had a bedside locker or a comfortable, supportive chair in their bedrooms
- the privacy of residents in bedrooms whose windows opened into the enclosed gardens was not adequately protected.

The inspectors were shown current work underway on a second enclosed garden area for residents. While inspectors appreciated that this was work in progress, it was highlighted to the provider that the ramp access and trip hazards identified needed to be addressed before the garden was used by residents.

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

**Findings:**
The complaints procedure was accessible and prominently displayed in the centre. It had named the complaints officer and independent appeals person and clearly outlined the process in place to ensure that complaints at the centre were managed. The complaints logs were reviewed and inspectors were satisfied that improvements and measures had been implemented to learn from complaints. The satisfaction of the complainant at the end of the process was also documented in all cases. The response to complaints was timely and the person in charge was able to discuss with inspectors in detail how complaints were managed in the centre.

**Judgment:**
Compliant

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**Outcome 14: End of Life Care**
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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

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

**Findings:**
Inspectors viewed the file of a resident who had been at end of life in the centre. However, there was inadequate documentation regarding the resident's spiritual, emotional and psychological needs. Many of the fields in the end of assessment form were blank and a detailed description of the resident's wishes after death or concerns was not outlined. Inspectors were not always assured that the physical needs of the resident at end of life were being appropriately assessed and monitored. The resident's notes indicated that they had poor oral intake and had been on bed rest however, an update of the oral hygiene assessment had not been completed in the previous 6 months. No fluid balance records were maintained considering the resident had poor oral intake. Contradictory accounts of pain control and pain management were also seen with a pain assessment recorded as comfortable on one day, however pain medication was administered on the next day for on-going pain. While inspectors saw documentation in the nurses daily notes about the care given to the resident, the gaps in care planning documentation were significant. There was evidence of regular visits by the general practitioner and specialist palliative care services were accessed when required. Visitors were facilitated to be with residents at end of life at all times.

**Judgment:**
Non Compliant - Moderate
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):
No actions were required from the previous inspection.

Findings:
The centre had an up to date policy for monitoring and documenting nutritional intake in the centre. Staff had received training on speech and language for nurses including dysphagia. Fresh drinking water was available to residents at all times. The inspectors viewed the menu plan for the centre and found that there was an adequate choice of meals. An up to date record of residents' dietary requirements was maintained in the kitchen so that meals were served appropriately to residents. The kitchen staff also had a record of residents' personal preferences in terms of their food likes and dislikes. The inspectors observed mealtimes in the centre. Most residents ate their dinner and evening meal in the dining room, with some residents choosing to eat in their bedrooms. Meals were well presented and residents on a modified diet had the same degree of choice as other residents. Residents with specific dietary needs, such as coeliac disease and diabetes, were catered for. Where residents required assistance this was given on a one to one basis.

While the centre had access to a dietician and speech and language therapist (SALT) by referral however, the implementation of the recommendations and recording of same in the residents’ care plans was not up to date or consistent. As outlined in Outcome 11 Health and Social Care Needs, recommendations for a specific texture diet and grade of fluid for one resident from SALT were not recorded in the interventions of the resident’s nutrition and oral hydration care plan. When residents' weights were monitored, the Malnutrition Universal Screening Tool (MUST) score or Body Mass Index (BMI) was not always calculated to appropriately interpret the residents' nutritional status.

Judgment:
Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

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

Findings:
Residents were consulted with regarding the organisation of the centre. There was a visitors' room where residents could meet with visitors in private. There were also options for each resident to participate in meaningful activities.

Inspectors reviewed minutes of resident’s meetings since December 2014. These meetings had occurred each month since then. The topics discussed centred on the activities that the residents had participated in, the option to adopt a pet dog within the home and celebratory activities such as a barbeque and Christmas party. Residents were able to offer feedback on how activities and events went both within these meetings and within feedback surveys. Additionally there was a feedback box by reception that would allow for anonymous feedback.

Residents had access to independent advocacy services. Resident’s independence was maximised through respect for their own daily routine. Residents were facilitated, where appropriate, to visit town with family or friends and to participate in activities external to the centre. Inspectors observed residents leaving for day trips and appointments with relatives or friends. Visitors were met with and they informed inspectors that there are unrestricted visiting hours. Residents had access to a wireless telephone to make or receive telephone calls.

Inspectors sat in with residents for one of their activity sessions and observed that there was a familiar and cordial relationship between staff and residents. Afterwards inspectors spoke with the activities co-ordinator about her system for ensuring that activities are varied and meaningful to residents. The co-ordinator’s knowledge of residents’ preferences reflected what residents had told inspectors.

Judgment:
Compliant

Outcome 17: Residents’ clothing and personal property and possessions
Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Residents had adequate storage facilities in their bedrooms to store their clothing and personal belongings. However, in one bedroom the wardrobe space for a resident was inadequate and this was highlighted to the provider. Also, no lockable storage facility was available for residents in their bedside locker or wardrobe to store valuables or personal items. This was addressed under Outcome 12 Safe and Suitable Premises.

There were up to date records of residents' property and clothing maintained in their files. The residents' personal laundry was contracted to an external launderette. However, residents clothing was not all labelled to indicate who it belonged to and prevent any misplacement of residents' clothes in the centre or on return from the launderette. In addition, there was evidence of items of clothing were missing on return from the laundry in the customer feedback surveys.

Judgment:
Non Compliant - Moderate

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

Theme:
Workforce

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

Findings:
Staff rosters were reviewed by inspectors and a nurse was always on duty to meet the needs of the residents. Up to date nurse registration personal identification numbers were seen. Staffing levels at the centre were appropriate to meet the needs of the residents. The centre had a policy on the recruitment of staff and regular performance appraisals were conducted by the provider or the person in charge. All staff had a job description on file. However, a sample of staff files were reviewed and it was found that not all files had a full employment history, a document to verify Garda Síochána vetting or two written references from previous employers in place. This was addressed under Outcome 5 Documentation.

Staff training records were reviewed and all staff were found to have up to date training on fire safety, elder abuse, first aid and moving and handling of residents. However, not
all staff were trained to manage behaviours that challenge, and the moving and handling practices viewed by inspectors indicated that not all staff were appropriately trained as inconsistent practices were observed.

Staff were observed throughout the inspection to interact warmly and respectfully with residents. The inspectors spoke with many residents and visitors who all spoke positively about staff in the centre.

**Judgment:**
Substantially Compliant

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**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

**Report Compiled by:**

Aoife Fleming
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Louis Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000289</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>23/06/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26/08/2015</td>
</tr>
</tbody>
</table>

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 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose is not include all the items required by Schedule 1 of the Regulations:
- a description of all rooms and their size and primary function was not provided
- the list of facilities was not up to date as it did not list the hairdressing room or visitors room in the centre.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
1. **Action Required:**
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
A description of room sizes and primary function will be included in the new SOP and our new Residents Guide’s, also on completion of painting we will be erecting new signage in the building.

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

### 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:**
There was no annual review of the quality of safety and care 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:**
To comply with standards we are currently conducting outstanding review, this is been done by the PIC and ADON, going forward an annual management meeting is scheduled to be held at the end of December, to look at the quality of safety and care at the centre. The purpose of the review will be to look at existing care delivery and safety in the centre and if needed review all policies and objectives within the centre to ensure optimal care is being delivered at all times. These meetings will be attended by the POC & PIC along with staff involved in carrying out audits to ensure all aspects of care and safety are addressed. The findings of the annual review will then determine the plan going forward for the coming year.

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

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The person participating in management was on leave and had not been replaced which was acknowledged by the person in charge and the provider as an extra demand on their time.
3. **Action Required:**  
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**  
We have appointed an acting ADON whom has five years working experience with Care of the Older person and is employed by the centre as a full time nurse. All necessary forms are currently been completed and to be returned to HIQA.

**Proposed Timescale:** 31/08/2015

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**Outcome 03: Information for residents**

**Theme:**  
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Additional fees such as for hairdressing, chiropody and toiletries were not set out in the contract.

4. **Action Required:**  
Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

**Please state the actions you have taken or are planning to take:**  
Of the three contracts reviewed by the inspectors, these contracts were in place since 2010, all newer contracts in place have indeed the additional fees included as per regulations, we have now amended said contracts for those affected.

**Proposed Timescale:** 26/08/2015

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**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**  
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The fire management policy did not accurately reflect practice in the centre.

5. **Action Required:**  
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

**Please state the actions you have taken or are planning to take:**
Personal emergency evacuation plans will be put in place as outlined and included in our new care plans. Emergency lighting systems have now been serviced and a contract for yearly checks put in place to avoid recurrence. Our fire policy does not state that all fire doors open when fire alarm sounded, it states if activated the internal fire doors will automatically close, our main door opens automatically as per recommended by inspectors on the last inspection. Other means of escape are break glass key lock and all staff are trained and were issued with their own key for this purpose.

**Proposed Timescale:** 31/08/2015  
**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The inspectors were not reassured that a record of each drug and medicine was maintained at the centre, particularly in relation to PRN (as required) medications, as required by Schedule 3 of the Regulations. Not all staff files had a full employment history or two written references from previous employers or a Garda Síochána vetting form in place, as required by Schedule 2 of the Regulations.

6. **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:**  
On inspection there was in place monthly audits for psychotropic drugs, there is now in place a weekly audit tool for the administration and recording of all PRN psychotropic drugs that take place within the centre to avoid future discrepancies, these will be carried out by PIC/ADON. This will enable the PIC to check all PRN psychotropic drugs been administered and signed for in both MAR sheet and the stock book and the rational for their use is outlined in Residents nursing note’s, all staff nurses are signing the administration sheets and stock book. This will also enable us to monitor the amount of PRN’s being administered to each Resident and the pattern of their use. All staff were not complete as we are awaiting Garda vetting to be returned for 4 Casual staff and 1 fulltime staff member, we do however contact prior employer to check references and if they have Garda Vetting with that company, if so we ask for a copy so we can keep on file if possible while we await same. Not all staff have had two previous employers, we have asked that those outstanding documents be submitted to us or be suspended pending same, we now plan going forward to be more stringent on these requirements when employing new staff members.

**Proposed Timescale:** 31/08/2015

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The nominated person participating in management was on extended leave and no replacement had been arranged.

7. Action Required:
Under Regulation 33(1) you are required to: Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 33(2).

Please state the actions you have taken or are planning to take:
We have appointed an acting ADON whom has five years working experience with Care of the Older person and is employed by the centre as a full time nurse. All necessary forms are currently being completed and returned to HIQA.

Proposed Timescale: 31/08/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff were trained in behaviours that challenge.

8. 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:
On inspection the PIC did state to the inspectors that training DVD’s had been purchased to provide in house training for all staff members this was completed on the 28/07/2015 and we are a training session with a professional trainer for Behaviours that Challenge on the 31/08/2015.

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:
There were different versions of bed rail assessment forms in place and the form did not outline whether the 2 hourly review and release was appropriate for all residents.
9. 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:
The new care plans will include new restraint release forms which will be incorporated in our existing minute log to ensure regular review. The new care plan will include a bed rail assessment form, more centre specific to our Residents individual needs.

Proposed Timescale: 30/09/2015

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The practices referred to in the risk management policy regarding hazard identification and control were not all implemented or centre-specific. Risks were identified in the centre which had not been risk assessed or controlled:
- shaving foam being stored in unsecured presses in the shower rooms
- trailing wires were present in many residents’ bedrooms posing a risk of trips and falls
- not all showers had shower rails in place to assist residents
- deep drains in the enclosed garden areas posed a risk of trips and falls
- some resident bedside table tops were scuffed and worn and a deep clean could not be assured
- one bed had a rusty frame and flaking paint posing a risk of infection
- oxygen cylinders being used by a resident and stored in their bedroom were not appropriately identified as a fire hazard
- one external door had a key hanging on the door frame which was not risk assessed and posed a risk to residents
- several windows were unrestricted when open and had not been risk assessed
- the enclosed garden areas had not been risk assessed.

10. 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:
We are installing locks on presses in the bathrooms; all staff are aware each Resident has their own personal toiletries and that they be returned to room after use. Staff meeting held 30/06/2015 to reiterate same. All wires have been secured and a daily risk assessment tool put in place. Shower & Toilet rails have been put in place. Enclosed garden risk assessed and drains have been surfaced to avoid trips or falls. 17 Bedside tables have been ordered with 4 beds and 11 lockable lockers. 2 Sit out Chairs have
already been put in situ. Oxygen cylinder has been identified as a fire hazard, external door has been risk assessed and the key enclosed in a break glass unit. Windows have been risk assessed and restrictors attached were necessary.

**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:**  
The practice in place around sluice processes did not protect residents and staff from the risk of infection.

11. **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:  
Bed pan washer has been ordered and the date of delivery is end of August, we have in the interim put in place the use of disposable urinals and commode pans also in place is apron holder outside sluice room and a list of infection control guidelines is in place above apron dispenser. This is in place to reduce the risk of infection to Resident’s and Staff.

**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:**  
Residents did not have a personal emergency evacuation plan in place.

12. **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:  
The new care plans include detailed personal emergency evacuation plan’s which will be printed within the week.

**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:
The service records for the emergency lighting in the centre seen by inspectors were out of date.

13. **Action Required:**
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
Emergency lighting systems have now been serviced and a contract for yearly checks put in place to prevent reoccurrence.

**Proposed Timescale:** 31/07/2015

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### Outcome 09: Medication Management

**Theme:**
Safe care and support

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

When the inspector reviewed the balance of two residents diazepam dispensed medications, there was a lack of documentation to account for the administration of a significant number of PRN (as required) psychotropic medications (diazepam) with large shortfalls existing between the stock and what had been administered to the residents. Where medications were missing from the stock balance many were not accounted for in residents’ medication administration sheets or in records of medications returned to the pharmacy.

Not all maximum daily doses of PRN (as required) medications were prescribed.

Co-prescription of PRN (as required) paracetamol medications for residents, with cumulative doses exceeding the maximum daily dose, were seen.

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:**
On the day of inspection the PIC could not account for the shortfall of diazepam, however on the following day pharmacy return book for 2014 was checked in a bid to explain shortfall of named drug. There was an entry made in this book that was dated 13/02/2015 showing the return of 98 Diazepam which would account for shortfall. PIC acknowledges that this was an entry made in error to wrong book by a staff member, it did account for shortfall and this was also clarified by the pharmacy who sent the confirmation of receipt of this amount on the 13/02/2015. All this information was
forwarded to the inspector, the plan implemented to avoid any further discrepancy is that all PRN Psychotropic drugs are now sourced from local pharmacy and only seven day supply of all PRN Psychotropic drugs stock are kept in the centre. These are all recorded and logged in a stock book and are checked and signed for at the beginning and end of each shift by two staff nurses. This will give the PIC a clear account of the uses of said drugs and rational for their use. The Paracetamol charted was for both tablet and Maxalief (soluble) alternative and GP in question attended on the second day of inspection to discontinue Maxalief. All excess supplements had been removed on the day of inspections and were put for return to pharmacy. It was immediately put in place on the 30/06/2015 that all supplements would be sourced from the local pharmacy and only a two week supply would be ordered at a given time. This will enable staff to monitor expiry dates and better stock control measures. Those who no longer in need of supplements are now discontinued. Eye drops were disposed of on the day and staff have been instructed to complete medication management training and read ABA guidelines to medication management, to clarify as requested a weekly supply includes PRN/ Psychotropic drugs only and fortnightly supply refers to all other PRN medication’s in use within the centre.

**Proposed Timescale:** 31/08/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The inspector were not assured that the system for reviewing the expiry dates or storage of stock was not robust as there was a large quantity of nutritional supplements stored in a press which the person in charge acknowledged were not all required at that time. Some supplements were due to expire within two weeks after the inspection, however, there was no system in place to review and remove these items for disposal. Eye-drops which were in use did not have opening date recorded on the bottle.

**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:**
All excess supplements had been removed on the day of inspections and were put for return to pharmacy. It was immediately put in place that all supplements would be sourced locally and a two week supply would only be ordered at a given time. This will enable staff to monitor expiry dates and prevent over stocking of these supplements. Those who were no longer in need of supplements are now discontinued. Eye drops were disposed of on day and staff have been instructed to complete medication management training and read ABA guidelines to medication management.
Proposed Timescale: 30/06/2015

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:
Care planning documentation and updates in interventions were inadequate and not reviewed on an at least four monthly basis.

16. 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:
As highlighted to the inspectors, on inspection the care plans in place were in the process of being replaced due to the structure of them not being user friendly. The Care plans had both old and new templates in place which was confusing to staff and they therefore had not being accurately used, the PIC with the assistance of staff has now compiled a more centre specific and user friendly template for new care plans that all staff feel confident in using, these have now gone to print.

Proposed Timescale: 30/11/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The system of care plan documentation was not in line with the An Bord Altranais "Recording Clinical Practice Guidance for Nurses and Midwives" 2002.

17. 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:
As stated the new care plans are being implemented to ensure highest standard of individualised care. All care plans that are currently in place have been audited and any outstanding issues are being addressed.
Proposed Timescale: 26/08/2015

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 centre was not compliant with the requirements of Schedule 6 of the Regulations in the following regard;
- not all residents had adequate storage space as one resident's wardrobe space was inadequate
- signage in the centre did not identify the hairdressing room or the visitors room appropriately
- not all showers had been fitted with grab hand rails
- overall the centre required painting throughout as there was paint flaking from some walls and there were many scuff marks on the walls, door frames and skirting boards, giving the centre an unmaintained appearance
- the laundry storage room had damp coming through the walls, plaster was bubbling and paint was flaking off the walls
- there was no assisted bath in the centre
- the centre had inadequate sluicing facilities as there was no bedpan washer or sluice machine
- there was inadequate ventilation in residents' en-suite bathrooms and in a communal toilet
- one resident's en-suite bathroom was very dark even with the light on and had a faulty toilet
- there were no locks on the bedroom doors or on the doors of residents' en-suite bathrooms to ensure privacy
- there were no televisions in several bedrooms
- one two-bedded bedroom in particular was not decorated or personalised in a homely manner and was very dark
- not all residents had a bedside locker or a comfortable, supportive chair in their bedrooms
- the privacy of residents in bedrooms whose windows opened into the enclosed gardens was not adequately protected
- ramp access and trip hazards identified needed to be addressed before the garden was used by residents.

18. 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:
4 beds have been purchased 11 lockers with lock key access for residents have been ordered and a 3 week delivery timescale was given by company 17 bedside tables have been purchased so that now each resident has a functional and a good condition bed table. Each resident has now adequate wardrobe space. Each resident has now a
suitable chair in place. Grab rails completed. Painting of the premises had previously commenced and should be completed by early September. Bath will be replaced when bathroom is re designed to accommodate same and a time frame of November 2015 bed pan washer has been ordered and a four week delivery was given for delivery at the end of August to ensure effective infection control disposable commode pans and urinals are in place and clear infection control practice is in place aprons and gloves are to be worn on entering sluice.

Ventilation has been completed on communal bathroom and is also completed in the two en-suite rooms. Faulty toilet was fixed on day of inspection with a new washer and a new light fixture installed. There are keys to most bedrooms and we will risk assess same and ensure where safe all residents will have access to individual key. There were four Televisions outstanding these have now been installed. The two bedded room is on our list as first to be updated completion end of August. We guard our Residents privacy highly and have assessed the situation and will bring it to the residents meeting as to the preference for blinds or nets end of August. Ramps and trip hazards are in the process of been addressed in the rear garden on completion Prior to residents use. The court yard that residents have access to has been risk access and daily risk assessment in place.

All trip hazard have been made safe. the bathrooms have been fitted with privacy occupancy deadbolt locks which can be manually opened from outside in event of an emergency.

Proposed Timescale: 26/08/2015

Outcome 14: End of Life Care

Theme: Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate documentation regarding the resident's spiritual, emotional and psychological needs.
The resident's notes indicated that they had poor oral intake and had been on bed rest however, an update of the oral hygiene assessment had not been completed in the previous 6 months.
No fluid balance records were maintained considering the resident had poor oral intake. Contradictory accounts of pain control and pain management were also seen with a pain assessment recorded as comfortable on one day, however pain medication was administered on the next day for on-going pain.

19. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
The care plan has been updated to outline current needs. Resident was commenced on detailed fluid balance immediately, oral hygiene care to be now logged on fluid balance
chart and not in 30 minute log chart as had been the practice. The 30 minute communication sheet remains in place so that the PIC is reassured that the resident is been regularly assessed. Pain scale to be used at all times not adequate to record level of comfort in 30 minute log sheet. The needs and wishes of the resident are recorded on the end of life care plan and reviewed daily appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Proposed Timescale: 26/08/2015

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The implementation of the recommendations of the dietician and SALT, and recording of same in the residents' care plans, was not up to date or consistent. When residents' weights were monitored, the Malnutrition Universal Screening Tool (MUST) score or Body Mass Index (BMI) was not always calculated to appropriately interpret the residents nutritional status.

20. 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:
MUST training arranged for August for all staff. The implementation of the new care plans will lead to a more robust monitoring of MUST scoring. Monthly/Fortnightly weights continue and monthly assessments and audit continues to establish individual needs. Residents at risk will be reviewed by a dietician following three day recording and monitoring of diet as is best practice. SALT reviews were completed on three residents post inspection. They were not at risk of choking at this time even though they had been at risk in the past, it was said on inspection to the inspectors that where their concerns were appreciated the training that was received on dysphagia stated that if the residents did not have a history of recurrent respiratory tract infections/coughing post eating/drinking we were advised the no SALT review was warranted. All new care plans will be in place by September 2015.

Proposed Timescale: 30/09/2015

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents clothes were not all labelled to indicate who they belonged to and there were occasions of clothes going missing on return from the laundry.

21. Action Required:
Under Regulation 12(b) you are required to: Ensure each resident’s linen and clothes are laundered regularly and returned to that resident.

Please state the actions you have taken or are planning to take:
We ask all residents family’s to mark their clothing prior to entering the facility but not all residents are agreeable to this, were possible this is in place, laundry has been discussed and management had already decided that in house services would be best for all. Going forward on admission while property logs are being completed all clothing will be labelled by family or two staff members.

Proposed Timescale: 30/09/2015

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The wardrobe space for one resident was inadequate.

22. Action Required:
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
Wardrobe will be purchased as on list for order with other items.

Proposed Timescale: 31/08/2015

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 training in behaviours that challenge and resident moving and handling practices by staff were inconsistent.

23. 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:
In house DVD training on behaviours that challenge is to take place on 28th of July and professional trainer for behaviours that challenge is booked for the 31/08/2015. Staff have up to date manual handling training and will be made aware of their shortcomings at staff meeting and appraisal’s on practice to follow.

**Proposed Timescale:** 31/08/2015