<table>
<thead>
<tr>
<th>Centre name</th>
<th>Millhouse Care Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000252</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Newtown Commons, New Ross, Wexford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>051 447 200</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:nursing@millhousecarecentre.com">nursing@millhousecarecentre.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Clearwood Property Management In Receivership</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Pat Shanahan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Ide Batan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
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<td>Type of inspection:</td>
<td>Unannounced</td>
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<td>Number of residents on the date of inspection:</td>
<td>49</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>13</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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: 01 October 2015 09:30
To: 01 October 2015 16:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<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>Non Compliant - Major</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 - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection
This was an unannounced follow up inspection conducted on foot of a change in person in charge and receipt of unsolicited information by the Authority. The Authority had issued two separate provider led investigations to the Registered Provider as a result of receipt of unsolicited information. The Authority was satisfied with the Registered Provider’s response to the provider led investigations. The inspectors also followed up on any actions arising from the previous registration inspection of 24 September 2014. These actions had been completed.

Overall the inspector had concerns regarding the governance and management of the centre. There was a deficit in the management systems which inspectors found did not support and promote the delivery of quality care services. The person in charge was on leave for a continuous period of 28 days and the Authority had not been notified of this planned absence. The assistant director of nursing had only been in post for two weeks prior to the absence of the person in charge.

Inspectors were not assured that the deputy person in charge had adequate oversight of the designated centre. There were non compliances identified on this
inspection in relation to some fundamental and essential components of the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 including core aspects of governance which included:

Governance
fire safety
medication management
management of challenging behaviour
notifications
staff training.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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.
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:
A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

However, inspectors observed that information listed in the Statement of Purpose in relation to conditions of registration was incorrect. For example the expiry dates of registration of the designated centre.

Judgment:
Substantially Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found on the day of inspection that there was an organisational structure in place however improvements regarding management systems were required to ensure
compliance with the Regulations and to provide assurances to the Authority that the centre was being effectively governed ensuring residents were being delivered a service that was safe and met their needs. There was a provider nominee and a person in charge.

However, on review of staff rosters inspectors saw that the person in charge had been absent for a continuous period of 28 days. Inspectors also observed that there was one week on the roster where the person in charge had another planned absence and there were no definitive deputising arrangements in place as there was no deputy person in charge employed at that time. It was unclear who was in charge of the designated centre on that particular week given the planned absence of the person in charge. On the day of inspection the new deputy person in charge had only worked eight rostered days with the person in charge prior to her leave starting.

The deputy person in charge told inspectors that he was supported by the healthcare manager who was always available by phone or email. The practice development facilitator was present in the centre on the day of inspection. She told inspectors that her role was mentorship, support and guidance to the deputy person in charge. It was her first meeting with the deputy on the day of inspection. Inspectors found that the support provided by the Registered Provider was insufficient considering the absence of the person in charge in addition to the type and number of non compliances identified throughout the inspection. Inspectors were not satisfied that the deputy person in charge could ensure that the service provided was safe, appropriate, consistent and effectively monitored.

Inspectors were provided with an annual review of quality and governance dated July 2015. This had been compiled by the director of care services who was not based in the designated centre. Inspectors saw that this review was a collation of data in relation to non compliances identified from the organisations audit schedules. Inspectors could not identify from the data where improvements in outcomes for residents were clearly demonstrated or corrective action plans where required were developed and implemented. Inspectors were not assured that the annual review ensured that such care is in accordance with the relevant standards set by the Authority under section 8 of the Act.

Information governance required improvement. This review contained personal information regarding residents as observed by inspectors. Inspectors were informed that this document containing personal data was presented to staff on power point presentation at governance meetings. This is actioned under Outcome 5. Inspectors were not assured that the review was prepared in consultation with residents and their families and the deputy was unclear whether or not the review had been shared with residents.

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

**Findings:**
The records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are not maintained to ensure completeness, accuracy and ease of retrieval.

The inspectors reviewed staff files and found that not all staff files contained all of the information required by the regulations, for example, Garda vetting forms and references from most recent employers were not present in all files reviewed. In addition policies and procedures have not all been reviewed and updated to reflect best practice, for example the staff training and development policy viewed by inspectors has not been updated since 2009.

As outlined under Outcome 2 information governance required improvement.

**Judgment:**
Non Compliant - Moderate

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**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 Chief Inspector was not 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 the absence of the person in charge. Inspectors reviewed
staff rosters where it was shown that the person in charge was not present in the centre for a continuous period of 28 days or longer.

The provider had failed to discharge its obligation as required by regulation and notify the Chief Inspector of this proposed absence. Inspectors noted that arrangements had been made for a suitable qualified person to deputise in the absence of the person in charge. However, this person had commenced employment in the centre two weeks prior to the person in charge's absence. Inspectors formed the view that the provider had failed to ensure that this person had been in post for a sufficient period of time, prior to the person in charge being absent, to ensure the safety and quality of care was not adversely impacted.

**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:**
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy which provided guidance for staff to manage incidents of elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences. The policy outlined clear guidance for staff as to what their role would be in reporting and managing allegations or suspicions of abuse. It also included the name and contact details of a designated contact person. The training records identified that staff did not have up to date training in the protection of residents from abuse.

Inspectors saw documentation that confirmed incidents and allegations of abuse had been appropriately recorded, investigated and managed in line with the centre's policy, national guidance and legislation.

There was documentation in place regarding restraint and enablers. The policy on restraint was based on the national policy on restraint. Restraint measures in place included the use of bedrails. The inspector reviewed records with regard to restraint measures in place. There was a risk assessment completed prior to the use of the restraint. The risk assessments documented the safety issues with regard to using or not using the restraint measure and a balancing clinical judgment was made as to whether...
to use or not use the restraint measure.

There was a policy on challenging behaviour. Inspectors reviewed a care plan of a resident who presented with challenging behaviour. Inspectors saw that no assessment had been completed for this resident in relation to challenging behaviour. Inspectors did not observe any evidence of any support plans to sufficiently outline the antecedents and communication functions of the behaviours displayed which, when identified promptly, would guide staff to support residents in preventing incidents of behaviour that challenged. Only 11 staff out of 62 had received training in behaviours that challenge. There was a policy in place regarding residents' personal property and possessions. Where residents had access to their own personal monies secure storage systems were in place and records of all transactions were maintained.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Inspectors noted that all fire safety equipment had been serviced by suitable qualified personnel at the correct intervals. The minutes of health and safety meetings were reviewed and showed evidence of learning from incidents and actions being assigned and resolved by specific staff members. The risk management policy was in accordance with legislation. Evidence was seen of risk assessments being completed, updated and reviewed. These included the specific risks relating to abuse, unexplained absence of a resident, accidental injury, self-harm and aggression and violence as required by regulation. There was also a detailed process in place where identified risks could be highlighted to management.

Records were viewed which showed evidence of fire drills taking place however these records were not sufficiently detailed to determine how many staff and residents participated in each drill, the time of day the drill took place, whether the drill was announced or unannounced and any learning outcomes which arose from each fire drill. In addition inspectors noted that the log of daily checks of evacuation routes had been signed off every day by the same person for the continuous period of 18 August 2015 to 01 October 2015 even though this person only worked four days per week.

In addition records of fire training and infection control training viewed by inspectors showed that not all staff had received up to date training:
14 staff in fire safety
8 staff in infection control procedures

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe care and support

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

**Findings:**
Site specific and up-to-date written operational policies were in place for the safe ordering, prescribing, storing and administration of medicines to residents. Records were in place of staff who had read the policies. Practices observed in relation to the storage of medication were in keeping with policy, current guidelines and legislation and included appropriate refrigeration where necessary and suitably secure storage in the case of controlled drugs.

Staff observed administering medication did so in accordance with best practice. Documentation in relation to the prescribing and administration of medication contained all the necessary information to ensure the right medication was given to the relevant resident at the prescribed time and in accordance with the appropriate delivery method and dosage.

Where prescription records were transcribed by nursing staff it was clearly indicated as such and countersigned by a GP. Medication administration sheets contained the signature of the nurse administering the medication and prescription sheets contained the necessary biographical information including a photograph. There was adequate space to include comments in instances where residents refused medication or it was withheld. However, inspectors reviewed a sample of prescription and administration records and gaps were noted in administration records. Inspectors observed that many prescriptions were incomplete as they had not been individually signed off by the prescriber.

Some residents required their medications to be crushed prior to administration and a general authorisation to crush was identified on the front of the prescription record. However, each individual prescription did not contain an authorisation by the prescriber to crush the medicine prescribed.

A system was in place for reviewing and monitoring safe medication management. Quarterly audits were conducted by the pharmacist and weekly audits by the centre. Medication management was also a standing item at the staff nurse meetings. The deputy person in charge confirmed that should a resident wish to change pharmacist
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:
As on the previous inspection current and site-specific policies and procedures were in place in relation to the care and welfare of residents. Care plans and nursing notes were maintained electronically and care plans reviewed by the inspector contained evidence of pre-assessments undertaken prior to admission. On admission activities of daily living such as mobility, cognition, nutrition and communication were assessed and there was evidence that care plans were reviewed within four months, or as assessed needs required.

Documentation in care plans indicated that residents’ health care needs were regularly monitored with recorded assessments using standardised tools and referrals based on these assessments made in a timely manner.

Regular attendance by medical practitioners was in place and residents could retain the services of their existing GP by arrangement, or transfer to a local service of their choice depending on the capacity of the GP provider. Access to allied healthcare professionals such as a speech and language therapist and dietician was also available. A physiotherapist attended the centre on a weekly basis. Care plans reviewed contained the necessary documentation and correspondence around discharges and transfers which were complete and accessible.

Judgment:
Compliant

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:**
Policies and procedures which comply with legislative requirements were in place for the management of complaints. Inspector saw that the process was displayed in a prominent position. On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

**Judgment:**
Compliant

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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.

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**Theme:**
Workforce

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

**Findings:**
The inspector found that the levels and skill mix of staff were sufficient during the inspection to meet the needs of residents. The inspector checked the staff rota and found that it was maintained with all staff that working the centre rostered and identified. Systems of communication were in place to support staff to provide safe and ensure appropriate care. There were handovers each day to ensure good communication and continuity of care from one shift to the next.

There was a record maintained of An Bord Altranais professional identification numbers (PIN) for registered nurses. All registered nurses had up-to-date registration. However, appropriate supervision and guidance for staff was not found to be in place due to the lack of a robust management structure within the centre as outlined under Outcome 2.
A training programme is in place for staff but some staff have not received mandatory training, for example records viewed on the day of the inspection indicated that, out of a complement of 62 staff, up to date training had not been completed:
- 37 staff in the prevention of elder abuse
- 14 staff in fire safety
- 8 staff in infection control procedures
- 14 staff in the correct procedure for moving and handling of people
- 11 staff in how to deal with challenging behaviour

This deficit is not in line with the provider's own policy and does not satisfy the requirements of the Regulations. Staff files were examined as part of the inspection process and deficits were identified. This is dealt with and actioned under Outcome 5.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

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

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<tr>
<td>Date of inspection:</td>
<td>01/10/2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>28/10/2015</td>
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Requirements

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

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that information listed in the statement of purpose in relation to conditions of registration was incorrect. For example the expiry date of registration of the designated centre.

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:**
The Statement of Purpose contains 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; the conditions of registration are correct, and the expiry date of registration of the centre has been corrected.

**Proposed Timescale:** 28/10/2015

### 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:**

On review of staff rosters inspectors saw that the person in charge had been absent for a continuous period of 28 days. Inspectors also observed that there was one week on the roster where the person in charge had another planned absence and there were no definitive deputising arrangements in place as there was no deputy person in charge employed at that time.

2. **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 details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
The regional Healthcare Manager provided support to the centre during a week of planned leave for the PIC, prior to the appointment of a designated deputy. This was not evident to the inspector as it was not documented on the staff roster. However, staff on duty during this time was aware of the cover arrangements.

A definitive arrangement is now in place to support the management of the centre during scheduled leave or absence of the Person in Charge. This is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles and details responsibilities for all areas of service provision. An assistant director of nursing has been appointed who is the designated deputy to the PIC. He is responsible for the management of the centre during her absence and is supported in this by the regional healthcare manager. These arrangements will be clearly documented on the staff roster and all staff is aware.

The PIC was on scheduled leave for a 4 week period, but during this time she attended 4 study days off site (3 related to a management course and one was a wound care study day). This period of planned absence was not notified as a continuous absence of 28 days due to her attendance at study days on a regular basis throughout the leave period.
A NF20 and NF21 have now been submitted following the advice of the inspector.

**Proposed Timescale: 28/10/2015**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that the support provided by the Registered Provider was insufficient considering the absence of the person in charge in addition to the type and number of non compliances identified throughout the inspection. Inspectors were not satisfied that the deputy person in charge could ensure that the service provided was safe, appropriate, consistent and effectively monitored.

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:**
There is a management system in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. The clinical nurse manager received induction and orientation to the centre by the PIC. During the period of her scheduled absence, she was available to answer queries if needed. The regional healthcare manager was available and visited the centre regularly. The director of care services was available and visited the centre during the leave period of the PIC. The practice development facilitator also visited the centre.

Although the deputy to the PIC had been recently appointed, he was aware of his responsibilities, the line of authority and roles of people available to assist him within the organisation.

A definitive arrangement is now in place to support the leave or absence of the PIC, and this will be clearly documented on the staff roster and staff will be made aware.

**Proposed Timescale: 28/10/2015**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors were not assured that the annual review ensured that such care is in accordance with the relevant standards set by the Authority under section 8 of the Act. Inspectors could not identify from the data in the review where improvements in outcomes for residents were clearly demonstrated or corrective action plans where
4. **Action Required:**
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

**Please state the actions you have taken or are planning to take:**
The quality and safety of care are regularly reviewed through quality and governance meetings. The following areas are reviewed:

- Quality standards are assessed through a process of audit and actions to address non-compliant areas discussed.
- Clinical indicators, including falls (occurrence, management and prevention), use of restraint (comparing the average number of physical restraints in place per quarter over the past year), pressure sore and wound management, and nutritional assessment and management.
- Health and safety procedures and practices and progress in relation to physical hazard identification and risk reduction.
- Clinical hazards such as infection prevention and control, and an analysis of adverse incidents and events are discussed by reviewing the incidence and outcome.
- Residents and families’ views are gleaned through regular resident and family meetings and through the customer survey, which is conducted on an annual basis. Complaints received and their outcome, including the satisfaction of the complainant with the response.

The annual review conducted in July included an action plan for the coming year. We will produce a summary of improvement in outcomes for residents and an enhanced action plan based on the agenda areas outlined above.

**Proposed Timescale:** 31/01/2016

**Theme:**
Governance, Leadership and Management

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

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

**Please state the actions you have taken or are planning to take:**
On this occasion, resident and families’ views and feedback were not sought specifically when preparing the annual review; however, the centre takes account of feedback from residents and families in a number of ways, including comments/suggestions, annual...
survey, residents’ meetings and complaints analysis. Service and care improvements are implemented as a result of customer feedback. A summary of the presentation will be made available for them to read and their comments are always welcome.

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

**Theme:** Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The deputy person in charge was unclear whether or not the review had been shared with residents.

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

**Please state the actions you have taken or are planning to take:**
The annual review will be made available for residents to read, ensuring that no confidential information is shared. The contents of the review will be discussed at the next resident/family meeting.

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

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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:**
Policies and procedures have not all been reviewed and updated to reflect best practice, for example the staff training and development policy viewed by inspectors has not been updated since 2009.

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

**Please state the actions you have taken or are planning to take:**
All policies have been updated and reviewed, including the policy on staff training, education and development (HR-003).
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors reviewed staff files and found that not all staff files contained all of the information required by the regulations, for example, Garda vetting forms and references from most recent employers were not present in all files reviewed.

8. 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:
All records set out in Schedules 2, 3 and 4 are kept in the centre and are available for inspection by the Chief Inspector, including references from most recent employers. Outstanding Garda Vetting Forms are being processed and will be on the employees’ file when received in the centre. However, employee self-declaration forms are in place and on file for all staff.

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Information governance required improvement. The annual review contained personal information regarding residents as observed by inspectors. Inspectors were informed that this document containing personal data was presented to staff on power point presentation at governance meetings.

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

Please state the actions you have taken or are planning to take:
All records are maintained in such a manner as to be safe and accessible as appropriate. All information relating to residents has been anonymised and is not available for residents or families to view.
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 Chief Inspector was not 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 the absence of the person in charge. Inspectors reviewed staff rosters where it was shown that the person in charge was not present in the centre for a continuous period of 28 days or longer.

10. Action Required:
Under Regulation 32(1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

Please state the actions you have taken or are planning to take:
The Person in Charge had a planned period of annual leave of 4 weeks duration, and returned to the centre on the 28th day. During the 4 week period, the PIC attended 4 study days off site as part of her ongoing education and development (3 study days as part of a company management course and 1 study day on wound management). It was decided that this constituted a leave period of less than 28 days’ duration, due to her ongoing professional development commitments. On the advice of the inspector, a NF20 form has now been submitted, confirming the dates of the absence of the PIC and outlining the management arrangements for the centre during her absence.

Proposed Timescale: 28/10/2015

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:
Only 11 staff out of 62 had received training in behaviours that challenge.

11. 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:
Documentation of training and education undertaken has now been updated. Staff requiring training and updates on behaviours that challenge have received this training, with a small number of staff scheduled to receive this in November.
Proposed Timescale: 30/11/2015

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors saw that no assessment had been completed for a resident in relation to challenging behaviour. Inspectors did not observe any evidence of any support plans to sufficiently outline the antecedents and communication functions of the behaviours displayed which, when identified promptly, would guide staff to support residents in preventing incidents of behaviour that challenged.

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

Please state the actions you have taken or are planning to take:
The assessment and care plan referred to in the report has been undertaken and implemented. There is a focussed care plan on responsive behaviour in place. This includes details on triggers for challenging behaviours and de-escalation techniques to address the specific behaviours; this will ensure consistency of approach by all staff. The ABC chart is also in place. The plan of care will be reviewed periodically as the resident’s care needs change.

Proposed Timescale: 28/10/2015

**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:**
Eight staff out of 62 had up to date training in infection control.

13. **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:
Training and education has commenced for all remaining staff who require infection control training and/or updates. This will continue throughout November.
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:
Records were viewed which showed evidence of fire drills taking place however these records were not sufficiently detailed to determine how many staff and residents participated in each drill, the time of day the drill took place, whether the drill was announced or unannounced and any learning outcomes which arose from each fire drill.

14. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
A fire drill has taken place since the inspection. There is a record of the number and role of participants, the time and date, whether the drill was announced or unannounced and an evaluation of learning outcomes. This will be the template used in all future fire drills.

Proposed Timescale: 28/10/2015

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors noted that the log of daily checks of evacuation routes had been signed off everyday by the same person for the continuous period of 18 August 2015 to 01 October 2015 even though this person only worked four days per week.

15. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
A schedule has been introduced where the maintenance person carries out and signs for the daily checks of evacuation routes when he is on duty. For the days he is not on duty, the staff roster indicates that the nurse in charge carries out the checks and signs the fire register.

Proposed Timescale: 28/10/2015
Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of fire training viewed by inspectors showed that not all staff had received up to date training only 14 staff had up to date training in fire safety.

16. 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:
A health and fire safety training session has been carried out since the inspection and another session has been scheduled so that all staff who require training or an update will have received this by the end of November 2015. The training session includes fire prevention and safety, evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire sighting equipment, fire control techniques and the procedures to be followed should the clothing of a resident catch fire.

Proposed Timescale: 30/11/2015

Outcome 09: Medication Management

Theme: Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors reviewed a sample of prescription and administration records gaps were noted in administration records.

17. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
A review of medication incidents will be carried out and this will be discussed at the next quality and governance meeting and at the next staff nurse meeting, where any trends or common reasons for medication incidents will be highlighted. Each gap and signature omission will be documented as a medication incident and this issue has been highlighted to all staff nurses. All new staff nurses have undergone a medication
The PIC and ADON will monitor medication management practices on an ongoing basis. The medication management audit has been completed in October and an action plan has been completed.

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

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Inspectors observed that many prescriptions were incomplete as they had not been individually signed off by the prescriber.

Some residents required their medications to be crushed prior to administration and a general authorisation to crush was identified on the front of the prescription record. However, each individual prescription did not contain an authorisation by the prescriber to crush the medicine prescribed.

**18. 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:**
The GP (prescriber) has been in the habit of signing off groups of medication by clustering them in brackets and signing once. The PIC will ensure that the GP undertakes to sign each individual medication and that each medication to be crushed is authorised by the GP.

**Proposed Timescale:** 28/10/2015

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A training programme is in place for staff but some staff have not received mandatory training, for example records viewed on the day of the inspection indicated that, out of a complement of 62 staff, up to date training had not been completed:

• 37 staff in the prevention of elder abuse
• 14 staff in fire safety  
• 8 staff in infection control procedures  
• 14 staff in the correct procedure for moving and handling of people  
• 11 staff in how to deal with challenging behaviour.

19. **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:**  
All staff has access to appropriate training, including Adult Protection (Elder Abuse), fire safety, infection prevention and control, people moving and handling and responsive behaviour. Training sessions have been scheduled and will take place at regular intervals throughout November so that all staff that requires the training or updates can avail of a session. The training matrix will also be updated to ensure that it is an accurate reflection of training/education undertaken.

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

**Theme:** Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Appropriate supervision and guidance for staff was not found to be in place due to the lack of a robust management structure as outlined under Outcome 2 and the non compliances identified on this inspection.

20. **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:**  
There is now a robust management structure in place in the centre. The PIC has a suitable deputy to support her in the daily management of the centre. The centre is also supported by a regional healthcare manager who visits the centre on a regular basis.

**Proposed Timescale:** 28/10/2015