<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Castleturvin House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000327</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Athenry, Galway.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>091 850 800</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:castleturvinnh@gmail.com">castleturvinnh@gmail.com</a></td>
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<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<td>Registered provider:</td>
<td>Castleturvin Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Carmel Killeen</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>PJ Wynne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>39</td>
</tr>
<tr>
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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 2 day(s).

The inspection took place over the following dates and times

From: 04 November 2015 10:15
05 November 2015 08:30
To: 04 November 2015 19:00
05 November 2015 13:45

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>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>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>
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</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
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</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>Substantially Compliant</td>
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<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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Summary of findings from this inspection

This report set out the findings of an unannounced monitoring inspection. This inspection took place over two days. The inspector reviewed progress on the action plan from the previous inspection carried out in November 2013. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

There were 39 residents in the centre during the inspection. All residents were residing in the centre for long term care. The inspector judged there was an adequate staff complement with the proper skills and experience to meet the assessed needs of residents at the time of this inspection.

The inspector evidenced that residents were receiving responsive healthcare to meet their assessed needs. The staff supported residents to maintain their independence.
where possible. The building was comfortably warm. Residents have access to a safe enclosed garden.

Residents had opportunities to participate in meaningful activities, appropriate to their interests and capacities. There was a good quality and variety of food available to residents at each meal time.

The nurse management team and all staff interacted with residents in a respectful, warm and friendly manner. Staff demonstrated a thorough knowledge of residents’ needs, likes, dislikes and preferences.

A total of 12 Outcomes were inspected. The inspector found three Outcomes as moderately non compliant. These included Health and Safety, Health and Social Care Needs and Residents’ Rights, Dignity and Consultation. Six Outcomes were found substantially compliant with the Regulations and three compliant with the Regulations.

The main points in the areas identified as moderately non compliant relate to;

The psychosocial needs of two residents requires review to maximise their quality of life. The temperature of dispensing hot water at wash hand basins in resident’s bedrooms exceeded the maximum recommendation of 43°C. The use of CCTV in the library room used by residents and their families for private visits requires review to fully ensure privacy by visiting families.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.
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 accurately described the aims, objectives and ethos of the centre and the service that was provided.

The statement of purpose was updated since the last registration inspection and contained all the information required by Schedule 1 of the Regulations.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**
*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The inspector found that the management structure was appropriate to the size, ethos, and purpose and function of the centre. There was an organisational structure in place to support the person in charge.
There was evidence of quality improvement strategies and monitoring of the services. Clinical data was collected and reviewed by the person in charge. This included information on physical restraint management, falls by residents. Data was maintained on the amount and type of psychotropic and night sedative medication administered to residents.

The outcome of audit findings or quality improvement initiatives were not collated into a report on the quality and safety of care with copies made available to the residents or their representative for their information as required by the Regulations.

**Judgment:**
Substantially Compliant

### Outcome 03: Information for residents

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Each resident was provided with a contract of care. A contract of care was in place for the most recently admitted resident. The contract outlined the terms and conditions of occupancy. The cost of additional expenses incurred by residents was set out in the contract of care. This identified charges payable per items not included in the overall fee.

**Judgment:**
Compliant

### Outcome 04: Suitable Person in Charge

*The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.*

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
**Findings:**
The person in charge has not changed since the last inspection. She is a registered nurse and holds a full-time post. She was well known by residents. She had good knowledge of residents care needs and could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

The person in charge has maintained her professional development and attended mandatory training required by the Regulations. She has maintained her clinical skill up to date. Since the last inspection she has attended courses in dementia care, behaviours that challenge, management and leadership.

**Judgment:**
Compliant

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

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff.

The inspector found that medical records and other records, relating to residents and staff, were maintained in a secure manner. Records were stored securely and easily retrievable.

A sample of staff files were reviewed. The files were examined to assess the documentation available, in respect of persons employed. The majority of the information required by Schedule 2 of the Regulations was available in the staff files reviewed. However, Garda Síochána vetting was not present in two of the six staff files reviewed.

**Judgment:**
Substantially Compliant
**Outcome 07: Safeguarding and Safety**

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

**Theme:**
Safe care and support

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

**Findings:**
There was a policy on adult protection in place. This included the contact details of the HSE senior case worker to whom safeguarding concerns are referred. Residents spoken with stated that they felt safe in the centre. There was a visitors log in place. Entrance and exit doors were monitored by CCTV.

A senior staff member was a qualified adult protection trainer. Staff to whom the inspector spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. There was an ongoing program of refresher training in safeguarding vulnerable adults in place.

There is a policy on the management of behaviour that is challenging. Staff spoken with were very familiar with resident’s behaviours and could describe particular interventions well to the inspector for individual residents. There was evidence staff had completed training in behaviours that challenge in the sample of staff files examined.

Where residents had specialist care needs such as mental health problems there was evidence in care plans of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health. It was evidenced in medical files the community mental health nurse visited the centre routinely.

There was a policy on restraint management (the use of bedrails) in place. There was good evidence a restraint free environment was promoted. There were no lap belts in use. At the time of this visit there were 14 residents with two bedrails raised. A risk assessment was completed and reviewed regularly. There was evidence of family and GP involvement. There was evidence of trialling alternative and why they were unsuccessful in the documentation reviewed. Eight residents had requested the bedrails raised. However, the documentation did not outline how the raised bedrail supported the resident and ensured an enabling function.

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

Theme:
Safe care and support

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

Findings:
The governance arrangements to manage risk situations were specified. The risk management policy contained the procedures required by Regulation 26 and Schedule 5 to guide staff. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy and health and safety statement.

There was an emergency plan and this was found to be appropriate with identification of services and emergency numbers in the event of a range of possible occurrences. A missing person’s policy was in place.

Widow openings throughout were restricted in the interest of health and safety. However, the temperature of dispensing hot water at wash hand basins in resident’s bedrooms around the building exceeded the maximum recommendation of 43°C. No precautionary checks of water temperature were undertaken.

The inspector reviewed the fire safety register and training records. Staff to whom the inspector spoke confirmed their attendance at fire training and gave accounts of their understanding of fire procedures in the event of an outbreak of fire. An ongoing program of fire evacuation training was in place on the use of fire fighting equipment and progressive horizontal evacuation.

Fire safety equipment including the fire alarm, fire extinguishers, emergency lighting and smoke detectors were provided. Contracts were in place for the servicing of fire fighting equipment. Illuminated fire exit signage was in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed. Escape route plans were displayed on corridors to show the nearest escape exit.

There was not a system in place to ensure fire drill practices were undertaken routinely to reinforce the knowledge from annual training. Fire drills to record the scenario/type of simulated practice undertaken, time taken for staff to respond to the alarm, simulated drills to reflect a night time situation when staffing levels are reduced were not occurring. There was not a system developed to ensure evaluation of learning from fire drills completed to help staff understand what worked well or identify any improvements required. A template to develop personal emergency evacuation plans in the event of a
fire were sourced. Work was commencing to develop individual emergency exit plans for each resident.

There was a small number of residents who smoked at the time of this inspection. Individualised arrangements were in place. Cigarettes and lighters were held in safekeeping by staff for the majority of residents who smoked.

The training records showed that staff had up-to-date training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents needs. The moving and handling risk assessments require review. While one assessment detailed the type of hoist and sling size required the information was not specified for all residents using a hoist in the sample of care plans viewed.

The inspector noted that falls and near misses were well described. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a head injury was suspected. The falls policy outlined the procedures to complete neurological observation in line with best practice.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
There was a medication management policy in place which provided guidance to staff to manage aspects of medication from ordering, prescribing, storing and administration.

Each resident’s medication was dispensed from individual packages. These were checked on arrival against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error.

The prescription sheets reviewed were legible and distinguished between PRN (as needed), regular and short term medication. Nursing staff transcribed the medication orders. Two signatures were in place for each transcribed medication. The GP’s
signature was in place for each drug transcribed.

The medication administration sheets viewed were signed by the nurse following administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) Regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. However, the book to record the total amounts of controlled drugs was not well maintained. A notebook was added to the original register and pages were not secured.

There were three residents on a controlled drugs at the time of this inspection. The inspector checked a selection of the balances and found them to be correct.

**Judgment:**
Substantially Compliant

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

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

**Theme:**

Effective care and support

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

**Findings:**

There were 39 residents in the centre during the inspection. All residents were residing in the centre for long term care. There were 12 residents with maximum care needs. Ten residents were assessed as highly dependent and ten had medium dependency care needs. Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition. Twenty residents had a diagnosis of dementia, cognitive impairment or Alzheimers.

The arrangements to meet residents’ assessed needs were set out in computerised care plans. There was a good emphasis on personal care and ensuring physical care needs of residents were met.

A range of computerised risk assessments had been completed and were used to develop care plans. Recognised assessment tools were used to evaluate residents’
progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and continence needs.

The inspector reviewed four residents' care plans in detail and certain aspects within other plans of care. This included the files of residents with nutritional issues, protective dressings, potential behaviour that challenges, high risk of falls a recently admitted resident, and resident whom had a hospital admission.

Staff demonstrated good knowledge and understanding of each resident’s background in conversation with the inspector. There was documentary evidence that residents or their representative were involved in the development and review of their care plan.

The format of care planning has been changed since the last inspection. The clinical nurse manager is completing work to develop a holistic care plan for each resident. However, in the sample of care plans reviewed there was evidence risk assessments and care plans were not always updated at the required intervals. The timeframe between the review of some assessment to include dependency assessment and moving and handling risk assessments exceeded a period of six months or more in some cases.

The inspector identified a recently admitted resident did not have a comprehensive assessment completed with care plans developed within the timeframe required by the Regulations. At the time of inspection the resident was in the centre ten days and a plan of care to meet all needs was not in place.

Residents had good access to GP services and there was evidence of medical reviews. However, the treatment plan or recommendations were not always documented well in care files to provide clear oversight of medical input. Access to allied health professionals to include speech and language therapist, dietetic service and occupational therapy were available.

A number of residents were provided with air mattresses. Care staff completed repositioning charts for residents with poor skin integrity or whose spent significant periods of time in bed due to fragility.

Residents had care plans for nutrition in place. There was prompt access to the GP and allied health professionals for residents who were identified as being at risk of poor nutrition. There was ongoing monitoring of residents nutrition. Nutritional screening was carried out using an evidence-based screening tool. All residents were weighed regularly. Resident identified at risk were weighed on a more frequent basis. At the time of this inspection seven residents were being weighed weekly.

Where residents had specialist care needs such as mental health problems there was evidence in care plans of good links with the mental health services. The consultant psychiatrist and their team visit the centre as required to review residents. At the time of this inspection there were seven residents under the care of the psychiatry team. Medication is reviewed to ensure optimum therapeutic values. However, two residents needs were not being fully met. Options were being explored by the person in charge to include a psychology review for one resident. However, the residents psychosocial
needs were not adequately addressed. The residents did not have access to a day service at the time of inspection although discussions were instigated by the person in charge.

**Judgment:**
Non Compliant - Moderate

### 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:**
There was an end-of-life care policy detailing procedures to guide staff. The policy of the centre is all residents are for resuscitation unless documented otherwise. A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. However, residents with a do not resuscitate (DNR) status in place did not have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

Each resident had a plan of care for end-of-life. The care plans contained good detail of personal or spiritual wishes. Decisions concerning future healthcare interventions require review. Resident’s preferences with regard to transfer to hospital if of a therapeutic benefit were not documented in all of the end-of-life care plans reviewed.

**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:
There was evidence of a good communication culture amongst residents, the staff team and person in charge.

Residents were well dressed. Personal hygiene and grooming were well attended to by care staff. The inspector observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times.

Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. During the day residents were able to move around the centre freely. There was good signage to direct resident to bathrooms. However, there was no signage or visual cues to direct residents to communal areas, day sitting rooms or the dining rooms to assist promoting the independence of residents in particular those with cognitive impairment or dementia.

CCTV was in operation throughout the building. Notices were on display along the corridor. There was a policy to guide the practice. However, notices alerting residents and visitors to CCTV recordings were not in all areas where cameras were placed. The room referred to as the library is used by residents and their families for private visits. The use of a camera in this area requires review to ensure privacy of visiting families and residents.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by the activities coordinator, employed five days each week. The inspector spoke with the activity coordinator who confirmed the range of activities in the weekly program. The activity schedule provided for both cognitive and physical stimulation.

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):
No actions were required from the previous inspection.

### Findings:
The inspector judged there was an adequate complement of nursing and care staff with the proper skills and experience to meet the assessed needs of residents at the time of this inspection taking account of the purpose and size of the designated centre.

There are two nurses rostered throughout the day to meet the clinical care needs of residents. There are care staff allocated to remain in each day sitting room throughout the day. In addition there are activity staff present in the communal sitting rooms to facilitate a flexible program of activities to engage the residents meaningfully.

Staff demonstrated good knowledge and understanding of each resident’s background. Staff described residents preferred daily routines, like and dislikes in conversation with the inspector.

Information available conveyed that staff had access to ongoing education and a range of training was provided. The sample of staff files evidenced a program of ongoing training. However, the training matrix to provide oversight to ensure all staff training needs are met was not maintained up to date.

### 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:

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

<table>
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<th>Castleturvin House Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID</td>
<td>OSV-0000327</td>
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<tr>
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<td>04/11/2015 and 05/11/2015</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The outcome of audit findings or quality improvement initiatives were not collated into a report on the quality and safety of care with copies made available to the residents or their representative for their information as required by the Regulations.

1. 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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

**Please state the actions you have taken or are planning to take:**
An annual audit on the quality and safety of care will be completed and made available to residents and their representatives.

**Proposed Timescale:** 20/01/2016

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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:**
Garda Siochana vetting was not present in two of the six staff files reviewed.

2. **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:**
Both staff were Garda vetted by their previous employers and Garda vetting was applied for on application to their post and was being processed at the time of inspection. Garda vetting was processed on Dec 1st and posted out to us and is currently in their files.

**Proposed Timescale:** 09/12/2015

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Restraint assessment documentation did not outline how the raised bedrail supported the resident and ensured an enabling function.

3. **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 primary function for the use of bedrails is to ensure the safety of the residents and the risk assessments reflect the fact that they are restraints and are assessed, reviewed and monitored accordingly. The bedrails are not in place as enablers. In the current assessments, the resident’s opinion is included for example in one case where the resident has specifically requested bedrails to feel more secure whilst in bed. That is the sole enabling function of the bedrails but they remain documented as restraints with the rationale and opinion of the resident included in that documentation as per the National Guidance Policy.

**Proposed Timescale: 09/12/2015**

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

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The temperature of dispensing hot water at wash hand basins in resident’s bedrooms around the building exceeded the maximum recommendation of 43°C. No precautionary checks of water temperature were undertaken.

**4. Action Required:**
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

**Please state the actions you have taken or are planning to take:**
At the time of inspection the water temperature ranged from 40 degrees to 45 degrees maximum. The water thermostat has been changed to range from 38-43 degrees. Water temperature checks will be maintained in a weekly log to ensure compliance.

**Proposed Timescale: 09/12/2015**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The moving and handling risk assessments require review. While one assessment detailed the type of hoist and sling size required the information was not specified for all residents using a hoist in the sample of care plans viewed.

**5. Action Required:**
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.
Please state the actions you have taken or are planning to take:
All manual and handling risk assessments have been updated and assessment results have been inputted into the relevant care plans.

Proposed Timescale: 09/12/2015
Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was not a system in place to ensure fire drill practices were undertaken routinely to reinforce the knowledge from annual training. Fire drills to record the scenario/type of simulated practice undertaken, time taken for staff to respond to the alarm, simulated drills to reflect a night time situation when staffing levels are reduced were not occurring.

6. 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:
Although fire drills were carried out throughout the year, a new system has been put into place to carry out monthly drills with audits of the type of stimulated practice, response time and to be carried out at different times of the day/night. The results of the audits will be communicated to all staff for further learning.

Proposed Timescale: 09/12/2015
Theme: Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal emergency evacuation plans were not developed for each resident.

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

Please state the actions you have taken or are planning to take:
Personal emergency evacuation plans will be posted at the end of each bed in case of emergency.
Outcome 09: Medication Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The book to record the total amounts of controlled drugs was not well maintained. A notebook was added to the original register and pages were not secured.

8. 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:
The checking log which is separate to the controlled drugs register is recorded in a notebook/diary. This was replaced on the day of inspection as it had come towards the end of the notebook.

Proposed Timescale: 09/12/2015

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:
In the sample of care plans reviewed there was evidence risk assessments and care plans were not always updated at the required intervals. The timeframe between the review of some assessments exceeded a period of six months or more in some cases. This included dependency assessments and moving and handling risk assessments.

9. 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:
An audit carried out of the electronic records shows that 95% of all care plans and assessments had been reviewed within the 4 month timeframe. The outstanding assessments/care plans have been updated.
**Proposed Timescale:** 09/12/2015  
**Theme:**  
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
A recently admitted resident did not have a comprehensive assessment completed with care plans developed within the timeframe required by the Regulations. At the time of inspection the resident was in the centre ten days and a plan of care to meet all needs was not in place.

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

**Please state the actions you have taken or are planning to take:**  
On admission, care plans were discussed with the resident and the resident had signed the admission document, 6 assessments had been carried out on admission, 6 care plans had been commenced but required further personalization which has been carried out. A comprehensive assessment which was partially completed is now fully completed.

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**Proposed Timescale:** 09/12/2015  
**Theme:**  
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The treatment plan or recommendations by GP’s were not always documented well in care files to provide clear oversight of medical input.

11. **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:**  
The G.P’S recommendations and treatment plan are always documented in the nursing notes of the residents who are reviewed. The G.P rounds book also lists the residents seen and treatment recommendation. We encourage the G.P to maintain their own records which includes the use of electronic or paper records as much as is possible.
Proposed Timescale: 09/12/2015

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The psychosocial needs of two residents were not adequately addressed as the residents did not have access to a day service at the time of inspection.

12. 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 Chnáimhseachais.

Please state the actions you have taken or are planning to take:
One resident is now back attending the day centre following a period of ill health due to the ongoing input of all involved. This resident was also seen by a psychologist on the first day of the inspection which was organised by the person in charge prior to the inspection.

It was mentioned that another resident would benefit from the day service which was communicated to the psychiatric team. However this resident does not want to attend the day service. Attendance at the day service is sanctioned by the psychiatric team. We meet the residents’ psychosocial needs in every way possible as is within our control.

Proposed Timescale: 09/12/2015

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:
Residents with a do not resuscitate (DNR) status in place did not have the DNR status regularly reviewed to assess the validity of clinical the judgement on an ongoing basis.

13. 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:
DNR status are currently being reviewed with the Dr and the residents family and will be formally reviewed 6 monthly
### Outcome 16: Residents' Rights, Dignity and Consultation

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Notices alerting residents and visitors to CCTV recordings were not in all areas where cameras were placed.

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

**Please state the actions you have taken or are planning to take:**
CCTV notices are placed in reception, the dayrooms, the corridors, the nurses station, the kitchen and the exit doors to notify residents, visitors and staff.

### Proposed Timescale: 09/12/2015

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no signage or visual cues to direct residents to communal areas, day sitting rooms or the dining rooms to assist promoting the independence of residents in particular those with cognitive impairment or dementia.

15. **Action Required:**
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

**Please state the actions you have taken or are planning to take:**
Appropriate signage is being put in place.

### Proposed Timescale: 16/01/2016

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The room referred to as the library is used by residents and their families for private visits. The use of a camera in this area requires review to ensure privacy of visiting families and residents.

16. **Action Required:**
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

**Please state the actions you have taken or are planning to take:**
CCTV from the library has been disabled

**Proposed Timescale:** 09/12/2015

<table>
<thead>
<tr>
<th>Outcome 18: Suitable Staffing</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Workforce</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The training matrix to provide oversight to ensure all staff training needs are met was not maintained up to date.</td>
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17. **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:** The staff training matrix is now updated.

**Proposed Timescale:** 09/12/2015