

**Health Information and Quality Authority  
Regulation Directorate**

**Compliance Monitoring Inspection report  
Designated Centres under Health Act 2007,  
as amended**



<b>Centre name:</b>	Cahermoyle House Nursing Home
<b>Centre ID:</b>	OSV-0000412
<b>Centre address:</b>	Ardagh, Limerick.
<b>Telephone number:</b>	069 76 105
<b>Email address:</b>	jimdon@cahermoylehouse.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Candor Holdings Limited
<b>Provider Nominee:</b>	Martin Lynch
<b>Lead inspector:</b>	Julie Hennessy
<b>Support inspector(s):</b>	Louisa Power
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	35
<b>Number of vacancies on the date of inspection:</b>	7

## About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

**Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 21 September 2015 08:30 To: 21 September 2015 15:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Substantially Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

**Summary of findings from this inspection**

This report sets out the findings of an inspection of Cahermoyle House Nursing Home, which was announced three days prior to the inspection. This was a follow-up inspection that was carried out to monitor the compliance with the Regulations due to the high level of non-compliance identified during previous inspections in February and July 2015. This inspection will also serve to inform a decision in relation to an application by the provider to renew the registration of the centre.

Inspectors met with residents, the person in charge, the assistant director of nursing (ADON) and members of the staff team. Inspectors observed practices, the physical environment and reviewed documentation such as policies, procedures, risk assessments, residents' files and training records.

There was a suitably qualified and experienced person in charge of the centre. The person in charge was supported by an assistant director of nursing (ADoN), who had

significant experience in supporting residents with mental health needs. Other staffing changes had taken place since the previous inspection, including the recruitment of a nurse facilitator.

Inspectors found improvements in a number of key areas since the previous inspection, which had a demonstrable effect on improving residents' quality of life. These included the development of advocacy arrangements, consultation with residents, review of restrictive practices and increased scope and choice of activities for residents. Staff were observed on this, as on previous inspections, to support residents in a dignified and warm manner.

Failings identified to be at the level of major non-compliance at the previous inspection relating to restrictive practices, taking steps to find more suitable alternative accommodation for residents to meet their individual needs, medication management and ensuring that each resident had a written contract of care were no longer at the level of major non-compliance at this inspection.

The Authority did not agree the action plan response to Regulation 23(b) under Outcome 2 with the provider despite affording the provider two attempts to submit a satisfactory response.

However, a significant number of actions were outstanding since the previous inspection. Of 26 actions from the previous inspection, 11 had been completed, satisfactory progress was demonstrated in relation to four actions, 13 actions either had yet to be completed or sufficient progress was not demonstrated and finally, an additional action relating to staffing was identified.

Further improvement was required to the management of behaviour that challenges, care planning, medication management, staff training and staffing arrangements. These areas are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. Where the timeline for actions had not yet passed, outstanding actions are repeated in this report to allow for progress against such actions to be tracked through the provider's action plan response and in following inspections.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

Four actions were identified at the previous inspection. One action had been completed, one had been partially completed and the timeframe for two actions had not yet passed.

At the time of the previous inspection, a new person in charge had recently commenced in the centre and an assistant director of nursing (ADON) had recently been selected and was due to shortly take up the ADON role. Reporting structures had been clarified. The creation of a 'senior carer' position was planned. At that time, it was not possible to determine the effectiveness or otherwise of the changes to the management system or reporting structure.

At this inspection, it was found that the person in charge had the required skills, experience and qualifications to fulfil the role of person in charge. The person in charge was supported in his role by a suitably qualified and experienced ADON. A nurse facilitator had also commenced in the centre since the previous inspection. The person in charge told inspectors that recruitment was currently underway for additional nurses but that this was proving challenging.

The person in charge demonstrated progress had been made in a number of areas under his control. These included the development of advocacy arrangements, consultation with residents, review of restrictive practices and improved activities for residents. Such developments had a demonstrable effect on improving residents' quality of life.

However, as evidenced throughout this report, a number of other failings identified at the previous inspection had not been satisfactorily implemented. In addition, inspectors found that the ADON and nurse facilitator were being rostered onto night duty and

working weekends to address staff shortages during those periods. The number of actions outstanding since the previous inspection and the continuing non-compliances in some key areas, such as mandatory staff training, medication management and care planning, demonstrated that this arrangement was not acceptable. This will be addressed in the action under Outcome 18 'suitable staffing'.

It was not demonstrated that the person in charge had the authority required to make decisions relevant to the day to day provision of safe quality of care to residents in the centre. For example, where the person in charge had identified that stair-gates posed a potential risk of falls, the person in charge said that he was not able to take the necessary steps to address this. In addition, the person in charge said that he did not have the authority to choose to use agency staff at nights and weekends in lieu of senior staff.

Inspectors spoke with staff who outlined specific changes that supported them in their work such as clarification of roles and responsibilities. Staff also said that the creation of the 'senior carer' post was working well and was beneficial in terms of improved communication.

At the previous inspection, it was found that audits, including those relating to medicines management, were limited in scope, audits did not identify some of the pertinent deficiencies and action plans were not always generated to ensure that actions were completed in a timely fashion.

The provider's response following the previous inspection was received on 25.08.15. In that response, the provider outlined that a new and more robust audit system had been formulated and was in the process of being implemented, with the first audits to be completed within two weeks (of 25.08.15) and the resulting audits and action plans to be completed by 30.09.15. At this inspection it was found that a medication management audit had been completed and templates were in place for the completion of other audits. However, sufficient progress was not demonstrated as other audits and action plans had not been completed in accordance with the provider's action plan.

With respect to the annual review and subsequent report, there were three actions identified at the previous inspection. One action had been completed and two further actions had timescales that had not yet passed so will be repeated as actions this report to allow progress against such actions to be tracked. The relevant actions related to a quarterly review to be completed on 29.10.15 and an annual review to be completed on 28.01.15. However, an annual review of the quality and safety of care delivered to residents in the centre is a requirement under the Regulations and such a review had not been completed within the previous 12 months.

**Judgment:**  
Non Compliant - Major

***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):**

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

**Findings:**

Three actions were identified at the previous inspection. Two actions had been completed. It was not demonstrated that the third action had been satisfactorily progressed in order to meet the proposed timeframe of 30.09.2015.

At the previous inspection, it was found that the residents' guide did not include the terms and conditions relating to residence in the centre. At this inspection, it was found that the residents' guide had been updated and now included the terms and conditions relating to residence in the centre.

At the previous inspection, it was found that where residents had contracts of care, they did not include details of the fees to be charged for services provided in the designated centre. At this inspection, it was found that contracts of care had been updated and now met the requirements of the Regulations.

At the previous inspection, it was found that six residents did not have a written contract. The provider's action to address stated that new contracts of care would be updated and agreed with the six residents by 30.09.2015. At this inspection, it was found that while the six residents had a written contract, the contracts had yet to be signed by the residents or their representatives. As the contracts of care were still in the centre awaiting signing, it was not demonstrated that the timeframe of 30.09.2015 could be achieved.

**Judgment:**

Substantially Compliant

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

**Theme:**

Governance, Leadership and Management

<p><b>Outstanding requirement(s) from previous inspection(s):</b> Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p><b>Findings:</b> At the previous inspection, improvements were required to some documentation to meet the requirements of Schedule 2, 3 and 4 of the Regulations. For example, a Garda vetting disclosure was not on file for one staff member, medicines administration records were not always accurately maintained and property/furniture lists had not been reviewed and updated.</p> <p>At this inspection, a sample of documentation under Schedule 2, 3 and 4 of the Regulations was reviewed. While documentation reviewed met the requirements of Schedules 2 and 4, it did not meet the requirements of Schedule 3. Medicines administration records were not always accurately maintained. An inspector reviewed a sample of medicines administration records and noted gaps to be evident when a medicine was due to be administered. As a result, the action had not been completed in full.</p>
<p><b>Judgment:</b> Non Compliant - Moderate</p>

<p><b><i>Outcome 07: Safeguarding and Safety</i></b> <b><i>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.</i></b></p>
<p><b>Theme:</b> Safe care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p><b>Findings:</b> Three actions were identified at the previous inspection. One action had been completed, one action was on target for completion and one action was outstanding.</p> <p>At the previous inspection, it was found that training had not been completed for all staff in relation to the response and management of behaviour that is challenging and some staff was unable to articulate adequate knowledge in this area.</p> <p>At this inspection, it was found that 12 staff still required training in relation to the response and management of behaviour that is challenging. It was not demonstrated</p>

that the timeframe to complete this action of 30.09.2015 would be met as no training was scheduled before then.

At the previous inspection, inspectors found that positive behaviour support plans had not been developed for residents to ensure a proactive approach in the management of behaviour that is challenging. Since the previous inspection, a behaviour support plan had been developed for a number of residents with significant needs in this area. The person in charge and ADON demonstrated that an accredited model was being used to develop these plans. Also, the support of a psychologist had been sought to review individual plans. While not all residents with behaviour that is challenging, including self-injurious behaviour, had a behaviour support plan, it was demonstrated that the accepted timeframe for completion of this action of 30.10.2015 was on target for completion. As the timeframe has not yet passed for completion of this action, it will be included for action in the action plan at the end of this report to allow for tracking and follow-up at future inspections.

At the previous inspection, inspectors found that restrictive practices, including bedrails and single separation, were not used in line with national policy published by the Department of Health. Since the previous inspection, the use of single separation had been reviewed. A review by the psychiatrist had taken place and a review of the behaviour support plan by a clinical psychologist had been arranged for the week of the inspection. It was demonstrated that the action required to address this failing had been satisfactorily completed.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Safe care and support

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

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

**Findings:**

Three actions were identified at the previous inspection. One action had been completed, one action was on target for completion and one action was outstanding.

At the previous inspection, it was found that the system for completing risk assessments required review. Some identified hazards did not have associated risk assessments. Other risk assessments required improvement. For example, there was no risk assessment for the absence of stair-gates at the top of stairs leading to the upstairs bedrooms. The infection control risk assessment did not include hand hygiene training

or auditing of practice as a control. There was no risk assessment for the risk posed by a threshold step in each en-suite shower in the 'West Wing'. The manual handling risk assessments were inadequate.

Since the previous inspection, while additional risk assessments had been completed as required, a hazard relating to blind cords had not been identified and inspectors observed a window cord that had not been made safe by the addition of an anti-ligature mechanism. Also, other areas relevant to risk management required improvement. The manual handling risk assessments did not provide sufficient guidance for staff and had not been developed with the input of a person competent in the area of manual handling. It was not demonstrated that the action required to address the risk to residents posed by threshold steps in 11 en-suite showers of the 'West Wing' would be addressed by the timeframe provided (30.09.2015) and this will be further discussed under Outcome 12. This was addressed by the person in charge during the inspection who asked a member of maintenance to address any unsecured blind cords in the centre.

At the previous inspection, the person in charge had identified a resident at risk of falling down the stairs. Since the previous inspection, temporary stair-gates had been installed. The provider in his response said that gates as permanent fixtures were being sourced, which would include touch pads for added security and would comply with fire regulations. The timeframe for completion of this action was 30.09.2015. It was not demonstrated that any progress had been made in relation to this action in order to ensure that the action would be completed by the timeframe of 30.09.2015. Of note, inspectors observed that the gates at the top of staircases presented an additional risk of falls. The stair-gates were at waist level and could be easily opened or left open in error by a resident. In addition, two of three stair-gates had been installed mid-way across the top step, effectively reducing by half the space on which to stand on the top step. The person in charge agreed that the stair-gates were not safe. Re-assurance was made in writing from the provider that the original timeframe of 30.09.2015 to install more suitable gates, as described in the previous action plan response, would be met.

At the previous inspection, it was identified that the system for reviewing the effectiveness of controls required review. Since the previous inspection, risk controls had all been reviewed and updated. Further work was required to the risk assessment documentation to allow for the residual risk rating to be captured following implementation of control measures. However, with respect to the risk assessments reviewed, it was evident that this was a documentation issue only. The ADoN and nurse facilitator were scheduled to attend a risk assessment course and would review the documentation following the course.

At the previous inspection, it was found that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were not implemented by staff. While the centre had an infection control policy in place, staff required training in relation to how to implement the procedures, including training in hand hygiene and how to prevent and manage healthcare associated infections. Hand hygiene and infection control audits were not in place. The infection control risk assessment required review.

Since the previous inspection, staff had received hand hygiene training and the infection control risk assessment had been reviewed and updated. An information folder had been compiled, with information relating to healthcare associated infections and national standards. Hand hygiene/infection control audits had not commenced, which were due for completion by 30/09/2015.

At the previous inspection, fire extinguishers were overdue the annual service. In the 'West Wing', the fire doors in the toilet and bathroom had been negated as holes were observed in those doors. At this inspection, it was found that the servicing of fire extinguishers had been completed. However, the holes in the fire doors in the toilet and bathroom had been filled rather than repaired. In addition, documentation relating to fire drills carried out on 12.2.2015 and 31.3.2015 did not indicate the time taken to evacuate the centre. Records from the most recent drill on 31.3.2015 included the comment that staff "need more drills or training" as staff were unable to identify the location of a fire. While all staff had received training in fire safety, no drill had taken place since that time. In addition, an inspector spoke with a staff member who was unable to articulate how to evacuate residents from the centre in the event of a fire. As a result, it was not demonstrated that the arrangements in place for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents were satisfactory.

At the previous inspection, it was identified (under Outcome 12) that in a vacant double bedroom on the first floor of the West Wing, exiting in the event of an emergency necessitated climbing three steps, traversing a room and descending four steps to exit via the dedicated fire exit. As a result, no resident residing in this room would be able to have any degree of mobility or cognitive impairment and would need to be fully independent. The person in charge told the inspector that advice from a competent person in the area of fire safety was required and would be obtained in relation to use of this bedroom before it could be occupied.

**Judgment:**  
Non Compliant - Major

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

**Theme:**  
Safe care and support

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

**Findings:**  
Three actions were identified at the previous inspection. One action had been completed and the timeframe for two actions had not yet passed.

At the previous inspection, the refrigerator was observed not to be locked. At this inspection, inspectors noted that a lock had been fitted to the fridge and the fridge was kept locked at all times.

At the previous inspection, a medication error was identified by an inspector. An inspector reviewed a sample of medication prescriptions and administration records and did not identify any medication errors on this inspection. The ADoN outlined that a new format of medicine administration records was to be introduced to reduce the risk of medication error. An inspector saw samples of these records. The ADoN confirmed that this system would be in place by 31 October 2015.

At the previous inspection, it was noted that references and resources were not complete to allow those administering medicines to confirm and identify individual medicines in the monitored dose system. The ADoN outlined that a new format of medicine administration records was to be introduced which would include identifiable information for each medicine in the monitored dose system. An inspector saw samples of these records. The ADON confirmed that this system would be in place by 31 October 2015.

Actions relating to medicines management are also discussed in Outcome 2:Governence and Management, Outcome 5:Documentation and Outcome 18:Suitable Staffing.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

Two actions were identified at the previous inspection. Inspectors found that while one action had been completed in full, the second action relating to care planning required further improvement.

At the previous inspection, it was found that the centre did not meet the assessed needs of all residents. Where this had been found to be the case, it had not been

demonstrated that steps had been taken to progress this since the previous inspection. At this inspection, it was demonstrated that this issue was being progressed and that where a needs assessment was required to expedite the issue, one had been arranged. In addition, the person in charge demonstrated that action had been taken in relation to source and secure an appropriate day service, where required, to any resident in the centre.

At the previous inspection, it was found that a comprehensive assessment of residents' social care needs had not been satisfactorily completed for all residents and care planning required further improvement. While improvement had been made in relation to meeting residents' social care needs, the failing in relation to care plans had not been fully addressed. Inspectors reviewed a number of care plans. Some care plans were individual, specific and directed the care to be given to each resident. Other care plans either had not been developed for identifiable needs or did not adequately direct the care to be given to each resident. For example, a resident on a modified diet did not have a care plan in place. Not all residents with mental health needs had a care plan to meet those needs. Care plans relating to mobility needs were generic and did not outline the individual supports required for each resident. Wound care plans lacked on-going objective assessment of the wound and did not record the dimensions of the wound. Photographs were not used to monitor the on-going progress of the wound

**Judgment:**

Non Compliant - Moderate

***Outcome 12: Safe and Suitable Premises***

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

**Theme:**

Effective care and support

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

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

**Findings:**

At the previous inspection, it was found that the premises did not fully meet the requirements under Schedule 6 of the Regulations. For example: in the communal area on the ground floor, there was an insufficient number of toilets; on the first floor of the 'West Wing' grab-rails had not been fitted in the shower of the unoccupied double room and the shower trays in every shower on this floor had a threshold step that residents had to step over to access the shower. In the (vacant) double bedroom in the West Wing, exiting in the event of an emergency necessitated climbing three steps, traversing

a room and descending four steps to exit via the dedicated fire exit. As a result, no resident residing in this room would be able to have any degree of mobility or cognitive impairment and would need to be fully independent. On the first floor of the 'East Wing', screening in the two double bedrooms was inadequate. The layout of the bed in one double bedroom was not acceptable. The bedrooms on the first floor of the 'East Wing' were confined in terms of space and were not suitable for any resident who required assistive or adaptive mobility aids or appliances.

At this inspection, it was not demonstrated that sufficient progress had been made to address the failings identified at the previous inspection relating to the premises. As a result, this outcome remains at the level of major non-compliance.

With respect to the insufficient number of toilets in the communal area of the ground floor, the provider's response specified that the two additional toilets would be completed by 20.09.2015. This timeframe has not been met. At the time of inspection, there were still two toilets available for use by residents in the communal area itself.

With respect to the finding that shower trays in every shower on the first floor of the 'West Wing' had a threshold step that residents had to step over to access the shower, the shower trays were to have been removed between the 01.09.2015 and completed by 15.10.2015. At the time of inspection, this work had not commenced.

With respect to the (vacant) double bedroom in the West Wing, which was not suitable for any resident with a mobility or cognitive impairment, a written risk assessment had been completed since the previous inspection. The risk assessment specified no resident will be considered for the double room in the west wing that has any cognitive or mobility impairment. The person in charge said that advice from a fire consultant would also be sought before the room would be occupied. This has been addressed under Outcome 8.

With respect to the first floor of the 'East Wing', the layout of the bed in one double bedroom was not acceptable. The bedrooms on the first floor of the 'East Wing' were confined in terms of space and were not suitable for any resident who required assistive or adaptive mobility aids or appliances. Screening in the two double bedrooms remained inadequate as shower curtains were in place instead of a more suitable style or type of privacy screening.

**Judgment:**  
Non Compliant - Major

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

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

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

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

**Findings:**

At the previous inspection, it was identified that the person nominated as the independent appeals person did not meet the requirements of the Regulations. In addition, clarity was required to the complaints procedure to ensure that it clearly outlined how complaints are managed in the centre.

At this inspection, it was found that one action had been completed in full and the second action was yet to be fully implemented. Inspectors observed that while the complaints procedure displayed prominently in the centre did outline include the details of the nominated person, other than the person who maintained a record of all complaints in the centre, this change was not reflected in the complaints policy made available to inspectors.

**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):**

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

**Findings:**

Three actions were identified at the previous inspection. At this inspection, two actions had been completed in full and one was outstanding.

At the previous inspection, it was found that formal consultation processes had yet to commence and required further consideration in relation to how residents' who chose not to participate in such meetings would be consulted with or represented. Since the previous inspection, a new residents' committee has commenced and will meet on a two-monthly basis. Inspectors reviewed minutes of the first meeting and found that they were very relevant to issues in the centre, including what activities residents enjoyed, how they found the food and any aspects they would like addressed. There was evidence that residents' views and opinions had been acted upon.

At the previous inspection, it was found that work was required to identify residents who may require an advocate and to ensure that such residents had access to such services. Since the previous inspection, contact had been made with an advocacy service, who had been invited to visit the centre and support staff in relation to how to identify residents who may not otherwise have the opportunity to avail of advocacy services.

At the previous inspection, it was identified that the screening in two double bedrooms was not adequate as screens were of a plastic material and were not sufficiently long from ceiling to floor. One screen did not fully close on one side. The provider's response outlined that new screening had been supplied on 01.09.2015. Inspectors found on inspection that this action has not been completed and the finding was unchanged.

**Judgment:**

Non Compliant - Moderate

***Outcome 18: Suitable Staffing***

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

**Theme:**

Workforce

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

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

**Findings:**

At the previous inspection, it was found that the centre's training records showed that staff did not have up to date mandatory and additional training, assessed as being appropriate. At this inspection, it was again found that training was outstanding. Two staff had not attended fire safety training. Training in relation to behaviour that challenges and related training in relation to the recording of incidents of challenging behaviour ('ABC' or 'Action, Behaviour, Consequence' training) had been cancelled. Twelve staff required training in relation to behaviour that challenges. Training had not been provided for nurses in relation to medicines management. Six staff had not completed initial manual handling training and two staff required refresher training. Infection prevention and control training had not been completed for four staff. The person in charge identified other required training relevant to residents' needs, including in relation to risk assessments (which was scheduled) and training in relation to specialist behaviour support and the development of behaviour support plans.

As previously mentioned, it was not demonstrated that arrangements in place in relation to the skill mix of staff were appropriate at all times to meet the needs of residents. Senior staff were working nights and weekends and this was having an impact on key areas that had been identified as requiring improvement at previous inspections. The impact was most noticeable in terms of the delivery of staff training, care planning, medication management and auditing of the quality and safety of the service.

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**Judgment:**

Non Compliant - Moderate

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Julie Hennessy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	Cahermoyle House Nursing Home
<b>Centre ID:</b>	OSV-0000412
<b>Date of inspection:</b>	21/09/2015
<b>Date of response:</b>	05/11/2015

### 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:**

It was not demonstrated that the person in charge was supported in terms of decision-making to take responsibility for the delivery of safe quality of care to residents in the centre.

#### **1. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management

<sup>1</sup> The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

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 response submitted by the provider to this action did not satisfactorily address the failings identified in this report. The Authority has taken the decision not to publish this response and is considering further regulatory action in relation to this issue.

**Proposed Timescale:**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Improvement was required in relation to auditing the quality and safety of the service.

**2. 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 are new audit systems in place which cover all aspects of the daily running of the home these will be completed by the end of the month at which time appropriate action plans will be put in place.

The addition of the new nursing staff will ensure more fluid auditing in future

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

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

An annual review of the quality and safety of care delivered to residents in the centre had not been completed within the previous 12 months, as required by the Regulations.

**3. 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 next annual review is due for completion on the 31/12/2015 and will be completed on that date.

The findings will be presented to the residents at the first resident forum in the new year.

**Proposed Timescale:** 28/01/2016

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

While progress had been made in relation to consultation with residents and their families, the timeframe in relation to the next review had not yet passed and so the effectiveness or otherwise of such consultation could not be determined. The provider had indicated that scheduled reviews include a Quarterly review by 29/10/2015 and an Annual Review by 28/01/2016.

**4. 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:**

The next annual review is due for completion on the 31/12/2015 and will be completed on that date.

The findings will be presented to the residents at the first resident forum in the new year.

**Proposed Timescale:** 28/01/2016

### **Outcome 03: Information for residents**

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

All residents now had a written contract. However, for six residents, the contracts had not been signed by the residents or their representatives to date.

**5. Action Required:**

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

**Please state the actions you have taken or are planning to take:**

All efforts to have these signed continue however it has been difficult to locate the relatives in question these will be and are being considered as a matter of urgency.

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

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

**Theme:**

Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Documentation reviewed did not meet the requirements of Schedule 3. Specifically, medicines administration records were not always accurately maintained.

**6. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**

The new Mar sheet system is in place medications are now checked in monthly rather than weekly the new system requires that one nurse and the pharmacist double check medications into the home.

The tic-tac is improved on the new system and the addition of an current Irish Medical Formulary further assists the nurses with the identification of medications.

In addition senior nurses now check the kardex's on a daily basis.

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

**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:**

Training had not been completed for all staff in relation to the response and management of behaviour that is challenging.

**7. 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:**

Management of aggression and potential aggression (MAPA) work shops and Action Behaviour Consequence (ABC) challenging behaviour work shop dates have been set and we are currently working through the staff and will complete all of this training by the end of December 2015.

**Proposed Timescale: 30/12/2015**

**Theme:**

Safe care and support

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

Positive behaviour support plans were to be developed for residents to ensure a proactive approach in the management of behaviour that is challenging by 30.10.2015.

**8. 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:**

Positive Behavioural Support plans will be in place for all the identified residents who require it by 30th of November 2015.

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

### **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 system for reviewing the effectiveness of controls required review. Inspectors observed that the gates at the top of staircases presented an additional risk of falls.

**9. 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:**

This has been done.

**Proposed Timescale: 22/10/2015**

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in**

**the following respect:**

Further improvement was required to ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. Hand hygiene/infection control audits were not in place.

**10. 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:**

Hand Hygiene/Infection control audits are now in place and will be conducted on at least a three monthly basis.

Random quality control checks will also be conducted.

All new staff attend infection control induction training and are required to make themselves familiar with the infection control and management policy.

**Proposed Timescale:** 22/10/2015

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was not demonstrated that risks identified on the previous inspection had not been adequately addressed. The holes in the fire doors in the toilet and bathroom had been filled rather than repaired.

**11. Action Required:**

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**

This will be completed by 5th November

**Proposed Timescale:** 05/11/2015

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was not demonstrated that the arrangements in place for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents were satisfactory. Some staff did not know what to do in the event of a fire.

Also, advice from a competent person in the area of fire safety was required in relation to use of bedroom 11 in the first floor of the 'West Wing' before it could be occupied.

**12. 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:**

Two fire marshals will be selected at the beginning of each shift one nurse one carer. Each of the marshals will be aware of their duties should the fire alarm sound. Dates have been set for new staff who still require fire training.

Fire drills have commenced and will now continue on a regular basis .

A competent person has been commissioned to provide advise of the fire safety in room 11 in the West wing. This room will not be occupied unless approved by the appropriate authority. The due date for the inspection is 11/11/2015.

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

**Theme:**

Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The risk management system in the centre required improvement. A hazard was identified in relation to stair-gates that placed residents at risk of falling down the stairs. It was not demonstrated that the action relating to the installation of more suitable stair-gates would be addressed by the timeframe provided (30.09.2015). It was also not demonstrated that the action required to address the risk to residents posed by threshold steps in 11 en-suite showers of the 'West Wing' would be addressed by the timeframe provided (30.09.2015). Finally, the manual handling risk assessments did not provide sufficient guidance for staff and had not been developed with the input of a person competent in the area of manual handling.

**13. Action Required:**

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

**Please state the actions you have taken or are planning to take:**

i. All upper stairwells are now key-padded gates have been added to the bottom of all stairs.

ii. Work on shower trays has commenced however complications have slowed the progress of same .The contractor has encountered concrete and steel under the existing shower trays. All further work on the remaining shower trays have been put on hold as we await a report from the contractor regarding interference with the structure

of the building floor .

iii. Risk assessments have been completed with regards to moving and handling of staff by the resident physiotherapist.

**Proposed Timescale:** 22/10/2015

### **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:**

There was a potential for medicines not to be administered as prescribed. References and resources were not complete to allow those administering medicines to confirm and identify individual medicines in the monitored dose system.

**14. Action Required:**

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

**Please state the actions you have taken or are planning to take:**

Irish Medication Formulary is now in place to support nurses with the new Marr sheet medication recording system as well as the new improved Tic-Tac system.

**Proposed Timescale:** 22/10/2015

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

**Theme:**

Effective care and support

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

Care planning required further improvement. Some care plans were generic. Care plans had not been identified for all assessed needs.

**15. 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:**

All care planning will be systematically reviewed in order that they will be bespoke and holistic in nature.

Future care planning will be based upon the activities of daily living.  
A seventy two hour initial assessment care plan will be introduced.  
Named nurse framework will be reviewed and resident reallocated.  
Link nurse framework will be introduced following the first clinical governance meeting.

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

## **Outcome 12: Safe and Suitable Premises**

### **Theme:**

Effective care and support

### **The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The premises did not fully meet the requirements under Schedule 6 of the Regulations. For example: in the communal area on the ground floor, there was an insufficient number of toilets; on the first floor of the 'West Wing' grab-rails had not been fitted in the shower of the unoccupied double room and the shower trays in every shower on this floor had a threshold step that residents had to step over to access the shower. On the first floor of the 'East Wing', screening in the two double bedrooms was inadequate. The layout of the bed in one double bedroom was not acceptable. The bedrooms on the first floor of the 'East Wing' were confined in terms of space and were not suitable for any resident who required assistive or adaptive mobility aids or appliances. Hazards identified at the previous inspection had not been adequately addressed, specifically, shower trays in 11 ensuite showers on the first floor of the 'West Wing' had a threshold step.

### **16. Action Required:**

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

### **Please state the actions you have taken or are planning to take:**

Work on the additional toilets and the shower trays is ongoing. The delays in providing shower trays and the problems with the shower trays are as outlined in Action Required no 13.

Grab rails will be fitted in the ensuite in the unoccupied room in the west wing prior to any occupancy.

Screening has been changed to more suitable material.

The room lay out has been changed.

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

### Outcome 13: Complaints procedures

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The complaints policy had not been updated to include the details of the nominated person, other than the person who maintained a record of all complaints in the centre.

**17. Action Required:**

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**

The complaints policy has now been updated and is in place.

**Proposed Timescale:** 22/10/2015

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

**Theme:**

Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

The screening in two double bedrooms was still not adequate as screens were of a plastic material and were not sufficiently long from ceiling to floor. One screen did not fully close on one side.

**18. 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:**

Completed.

**Proposed Timescale:** 22/10/2015

### Outcome 18: Suitable Staffing

**Theme:**

Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

It was not demonstrated that arrangements in place in relation to the skill mix of staff

were appropriate at all times to meet the needs of residents. Senior staff were working nights and weekends and this was having an impact on key areas that had been identified as requiring improvement at previous inspections. The impact was most noticeable in terms of the delivery of staff training, care planning, medication management and auditing of the quality and safety of the service.

**19. Action Required:**

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**

Two new nurses due to commence on 11th of November this will allow the Manager to roster the nurse facilitator and assistant director of nursing in a more constructive manner.

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

**Theme:**

Workforce

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

Mandatory training and training assessed as being appropriate to meet residents' needs was outstanding:

Two staff had not attended fire safety training. Training in relation to behaviour that challenges and related training in relation to the recording of incidents of challenging behaviour ('ABC' or 'Action, Behaviour, Consequence' training) had been cancelled. Twelve staff required training in relation to behaviour that challenges. Training had not been provided for nurses in relation to medicines management. Six staff had not completed initial manual handling training and two staff required refresher training. Infection prevention and control training had not been completed for four staff. The person in charge identified other required training relevant to residents' needs, including in relation to risk assessments (which was scheduled) and training in relation to specialist behaviour support and the development of behaviour support plans.

**20. 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:**

Fire training dates are being sought and set as are moving and handling for the staff who require it.

In addition Management of Aggression and Potential Aggression and Action Behaviour Consequence management of challenging behaviour workshops are being organised and dates are set for this training.

A nurse competency programme has been developed and will take the form of question and answer tests as well as practical competency assessments during drug administration rounds.

A risk assessment training course is currently being sought for the nurse facilitator and the director of nursing.

Staff will also be trained in the following areas

breakaway

safe and therapeutic handling as well as de-escalation of potential violent situations.

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