

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sancta Maria Nursing Home
Centre ID:	OSV-0000449
Centre address:	Gallow's Hill, Cratloe, Clare.
Telephone number:	061 357143
Email address:	sanctamarianursinghome@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Olivia English
Provider Nominee:	Olivia English
Lead inspector:	Mary Moore
Support inspector(s):	Paul Dunbar
Type of inspection	Announced
Number of residents on the date of inspection:	30
Number of vacancies on the date of inspection:	2

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
05 November 2014 09:30	05 November 2014 19:00
06 November 2014 09:15	06 November 2014 19:15

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Non Compliant - Major
Outcome 04: Suitable Person in Charge	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Major
Outcome 14: End of Life Care	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This inspection was the sixth inspection of the centre by the Authority and was undertaken in response to an application by the provider to renew registration. As part of the inspection process inspectors met and spoke with staff and residents, observed practice and reviewed documents including policies and procedures, accident and incident records, complaint records, clinical records and staff related

records. Prior to the inspection the provider was asked to distribute questionnaires to residents and relatives for completion on a voluntary basis; completed questionnaires were returned from five residents and four relatives; the feedback received was positive. The inspector also reviewed prior to inspection a questionnaire submitted by the provider early in 2014 relating to nutrition and end of life care, notifications received from the centre and information received from concerned persons in relation to the quality and safety of care and services delivered in the centre.

There were thirty residents living in the centre and two vacant beds. The registered provider is also the person in charge and in the body of the report these terms are used interchangeably but refer to the one person.

There was evidence of good practice and evidence of improvements made as seen in nutrition, end of life care and the overall standard of care planning. The provider had also made the decision to apply for a reduction in beds from 34 residents to 32 to address the issue of multi-occupancy rooms. An assisted bath had been installed.

However, overall the inspection findings were not sufficient to support a positive registration decision by the Chief Inspector. A substantial level of regulatory non-compliance was evidenced and of the eighteen outcomes inspected the provider was judged to be in major non-compliance with seven outcomes, in moderate non-compliance with six and compliant with five outcomes.

The non-compliance originated in the areas of; governance; staffing levels and staff supervision; measures and actions taken to protect residents from harm and abuse; complaints management and residents rights, dignity and consultation.

At the end of the inspection the findings, both good practice and where significant breaches had been identified were discussed at length by inspectors with the provider.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose was dated as reviewed in September 2014 and it contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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:

There was a clear management structure in place and as the person in charge was also the registered provider, she had the authority, responsibility and decision making autonomy for the service; this was clear from staff and residents and relatives surveyed. The person in charge was supported by an experienced person participating in the management of the centre (PPIM). There was also evidence that the governance

structure was kept under review and a staff member had been appointed to the role of senior care manager in May 2014.

Completed audits reviewed by the inspector supported that the quality and safety of care and services provided was monitored. A sample of completed audits included medication management, food and nutrition, the use of physical restraint, falls, documentation and manual handling. There was evidence to support learning and improvement in areas such as nutrition, end of life care and the use of restraint.

However, the inspection findings would also support that the management systems did not at all times ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. The evidence to support this judgement is discussed in detail in the respective outcomes and includes:

- the recorded hours of attendance of the person in charge
- the deployment of sufficient and effective staffing resources
- the supervision of staff
- the management of complaints
- actions to ensure that robust measures were in place to protect residents.

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):

No actions were required from the previous inspection.

Findings:

The centre had a guide which described the services and facilities available to residents. The guide contained all of the information required under Regulation 20 (2). However, the resident's guide stated that the centre was a member of a national representative group for nursing home owners. This was found not to be the case on interviewing the person in charge and was potentially misleading to prospective residents and their families.

The contracts reviewed by the inspectors were signed by the resident (or their next of kin where appropriate) and by a representative of the centre. The inspector found a number of issues with the contracts which did not comply with the regulations. On the day of inspection there were 27 contracts available while there were 30 residents living in the centre. In addition, some contract templates had not been completed properly. For example, there were blank spaces where the name of the nursing home should have

been filled in. Inspectors also noted that some contracts did not contain the fees payable by residents. There was also a lack of clarity in some contracts in relation to additional fees/charges to be paid by residents.

Judgment:

Non Compliant - Major

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 was also the registered provider and therefore had enhanced authority, accountability and responsibility for the provision of the service. The person in charge was a registered general nurse and evidence of her current registration with her regulatory body was in place. The person in charge had the required experience having undertaken the role since 2001. There was documentary evidence that the person in charge engaged in ongoing education and training including mandatory and clinical training such as wound prevention and management, medication management, palliative care, nutrition, venepuncture and pain management. It was evident from relatives surveyed and residents spoken with that both groups were familiar with the person in charge.

However, retrospective actual rotas seen by inspectors indicated that the hours of attendance recorded for the person in charge on a weekly basis were inconsistent and at times insufficient, and that when present the person in charge was frequently the only nurse on duty. The person in charge told inspectors that the rota was not an accurate reflection of the rota she actually worked. The person in charge told inspectors that she was satisfied that staffing levels and skill-mix did not impinge on her ability to perform her management duties.

Judgment:

Non Compliant - Major

Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against

accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Governance, Leadership and Management

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

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

Findings:

With the application to renew registration the provider submitted evidence that the centre was adequately insured including against loss or damage to a resident's property.

Throughout the inspection process inspectors referred to and reviewed the records listed in schedules 2,3 and 4 of the regulations.

The directory of residents was adequately maintained.

Staff files were largely complete but evidence of current registration details with their regulatory body was not in place for two staff nurses employed.

The person in charge confirmed that a record of the on-going medical assessment, treatment and care of one resident by their GP was not maintained in the centre.

Where it was reported that psychiatric referral and review had been sought and psychological review had been requested, records were not in place and available for inspection to confirm that such reviews had taken place.

Policies on the use of CCTV and the management of accidents and incidents were not adopted and implemented in practice.

Improvement was required in the record keeping of receipts relating to residents finances.

Judgment:

Non Compliant - Moderate

***Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.***

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Staff were aware of the notification requirements for the absence of the person in charge and confirmed that there had been no absence that required notification to the Chief Inspector. There was a suitable person participating in the management of the centre (PPIM) available who was willing to and had experience of deputising for the person in charge.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Based on records reviewed and staff spoken with, including the provider, inspectors were not satisfied that measures in place were sufficiently robust to ensure that residents were at all times protected from harm and abuse. Inspectors were not satisfied that complaints made of alleged abusive behaviour were adequately, appropriately, objectively and fairly investigated to transparently support a conclusion by the provider that abusive behaviour did not occur. Inspectors were not satisfied that barriers were not in place to disclosures of alleged abuse.

The methodology of providing staff training was not adequate. All staff spoken with confirmed that they had viewed a DVD on recognising and responding to any alleged, reported or suspected abuse; two staff had recently completed the train the trainer programme with the intention of providing further training in house. Staff spoken with had adequate understanding of their responsibility to report to the provider but records seen indicated that this was not always the case. Staff did not have an adequate appreciation of the covert nature of abuse, or how the perception of staff behaviours may be radically different to a staff member as opposed to a resident. It is difficult to see how further in house training would address this.

Based on the records seen inspectors concluded that in response to complaints of

alleged abusive behaviours, there was an unfair and inequitable burden of blame attributed to the alleged victim of the alleged abuse. Inspectors were concerned that the alleged victim was recorded by staff as feeling humiliated, bullied and blackmailed into complying with a requirement from the provider to provide a written apology to the alleged perpetrator. Records seen suggested that this apology could be construed as necessary to ensure ongoing residency in the centre.

Based on the records seen inspectors would not view the actions taken by the provider as reasonable or proportionate. The language used in records seen was subjective such as "set on", "paranoia" and "self-pity stories"

Having reviewed the centres policies on recognising and responding to abuse and the management of complaints it was not clear as to which procedure was applied to manage the allegations made. There was no clear rationale as to the role and decisions made by staff members other than the provider/person in charge in the management of these allegations

There was no evidence to indicate that the alleged victim was provided with the required supports in relation to formally convened meetings, formal letters issued by the provider or the requirement to provide a formal apology.

Records reviewed did not demonstrate an evidence based understanding of and a therapeutic response to behaviours that may have challenged. It was recorded that a resident who demonstrated behaviours that challenged staff, was also at times visibly emotionally upset and at other times demonstrated withdrawn behaviour. However, records seen did not support that an appropriate assessment of the resident was undertaken by the appropriate healthcare professional to establish the exact nature and aetiology of the recorded behaviours.

There was no evidence of an understanding of potential antecedents to behaviour including psychological well-being or staff behaviours that may have triggered such behaviours, with an emphasis on personalisation and blame: this was evident from the "incident" records reviewed by inspectors. The records demonstrated a problem based approach to residents demonstrating behaviours of a challenging nature. Care plans in place for the management of challenging behaviours were vague; behaviours were not specified, potential triggers were not identified, therapeutic management strategies were not identified.

Judgment:

Non Compliant - Major

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

Theme:

Safe care and support

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

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

Findings:

The health and safety statement was dated February 2013 and incorporated the risk register. There was an adequate range of centre specific risk assessments completed including the measures in place to reduce risk. However the risk assessments had not been updated to reflect regulatory changes and there was no risk assessment in place for abuse as required by Regulation 26 (c).

While a record of accidents occurring in the designated centre was maintained, the person in charge confirmed that the risk register did not include the arrangements for the identification, recording, investigation and learning from incidents involving residents. This had been also been identified by the last inspection of the centre. The most recent quarterly audit of accidents completed by the person in charge in October 2014 identified some deficits in the management of incidents by staff including not advising the GP and the non completion of neurological observations. Based on the audit findings the person in charge had a policy in draft on incident reporting procedure.

The fire register was well maintained and in it the inspector saw certificates to support the inspection and testing of fire safety systems at the prescribed intervals. Fire fighting equipment had been serviced in October 2014; the fire detection system was serviced quarterly and annually most recently in September 2014; the emergency lighting was inspected in January 2014. Certificates of fire retardant status were also maintained. Staff maintained further records of in-house fire safety checks on a daily, weekly and monthly basis. A personal emergency evacuation plan (PEEP) was in place for each resident. Training records indicated that all staff had attended fire safety training including simulated evacuation exercises; staff spoken with confirmed their attendance and articulated adequate knowledge of actions to be taken in the event of fire.

However, a further review of fire safety precautions was required as inspectors noted that one fire escape route at lower ground floor level was obstructed. Another fire escape route deemed suitable on the PEEP for the evacuation of dependent residents had a step up to it and a redundant key box was still in place.

Any practice necessitating the occlusion of a fire/smoke detector required review.

There was an emergency plan that set out the contingencies in place for responding to incidents such as the serious disruption of essential services; a generator was also available on site.

Training records indicated that all staff training requirements in manual handling were within mandatory timeframes; certificates were in place confirming that hoists and slings had been inspected and serviced in October 2014. The inspector saw that residents had current manual handling plans that set out the equipment, staff and assistance required for each manual handling manoeuvre.

Resident consumption of tobacco was facilitated and a designated area was provided; some residents spoken with confirmed that it was their choice to spend their day in the room and it was therefore homely in presentation. Tobacco consumption was guided by policy, a generic risk assessment and individual resident risk assessments. The location and layout of the room allowed for its observation, staff were seen to observe the area, suitable fire fighting equipment was available and inspectors saw that where controls such as the restriction of smoking materials were identified that these were implemented. Staff spoken with said that the fire training programme included the procedures to be followed should the clothes of a resident catch fire.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

Overall and in balance there was evidence that staff adhered to appropriate medication management practices; practice was guided by written operational policies and procedures and staff reported collaborative working arrangements with the pharmacist.

The inspector saw that all medications were securely stored and procedures were in place for the management of controlled drugs in line with current guidelines and regulations including stock balance checks at each change of shift: the stock balance was seen to be correct.

Staff reported that no resident was managing their own medication and that there were no medication errors to report.

The inspector saw that medical authorisation was in place for medications required in an altered format (crushed); the maximum daily dosage of PRN medications (medication that is not scheduled or required on a regular basis) was clearly stated. A refrigerator was available specifically for medications and its temperature was seen to be monitored daily.

There was evidence that medication management was the subject of regular audit by the person in charge and that each resident's medication regime was reviewed at intervals by the pharmacist.

However, transcribing practice was not in line with local policy or regulatory body guidance that requires risk reducing strategies. The medication prescription record was routinely transcribed by the person in charge, whereas local policy stated that transcribing "should be avoided where possible". While staff said that the transcribed record was checked by a second nurse following transcription in order to minimise the risk of error, this was not outlined in policy or recorded on the prescription record.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Deficits noted in the management of accidents and incidents are discussed in Outcome 8; Health and Safety and Risk management. For the purpose of monitoring compliance with this outcome the inspector saw that a record was maintained of incidents/accidents occurring in the designated centre.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Overall there was evidence to support that residents' healthcare requirements were adequately and regularly assessed and that arrangements were in place to meet assessed needs. However, a significant deficit was identified in the management of behaviours that challenged including seeking the appropriate referral and advice; this was addressed in detail in Outcome 7.

The person in charge reported that residents were facilitated to retain the service of their preferred General Practitioner (GP) following admission and approximately seven GPs attended the centre. The person in charge said that residents had access to timely GP review and treatment based on nursing referral and a sample of medical records seen concurred with this. There was further documentary evidence that residents were supported to have appropriate access to other required healthcare in line with their needs including physiotherapy, speech and language therapy, dietetics, chiropody, dental care, psychiatry of later life and the acute hospital sector for the ongoing management of established health conditions such as diabetes.

The inspector saw that each resident had a nursing plan of care. The centre had recently introduced a computerised system of care planning and based on a random sample of records reviewed inspectors were satisfied that the system was clearly understood by staff. There was evidence that each care plan was informed by assessment and reassessment as required and at a minimum three monthly. Care plans were completed in consultation with the resident and were supported by a suite of validated assessment tools. Care plans were person centred, clearly set out the arrangements to meet identified needs as specific to each resident and incorporated interventions prescribed by other healthcare professionals.

Where a resident refused treatment, this was recorded and brought to the attention of the appropriate service.

Residents' vital signs were monitored and recorded monthly, seasonal flu-vaccine was administered and there was evidence of regular blood profiling as a means of evaluating well being and managing treatment regimes such as insulin and anti-coagulants.

The reported incidence of wounds was low and the inspector saw that risk was assessed, preventative equipment was in place, wounds were assessed, measured and graded and care was supported as necessary by the GP and wound care specialist.

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):

No actions were required from the previous inspection.

Findings:

Prior to the initial registration of the centre by the Authority the provider invested significantly in the premises to facilitate regulatory requirements. In line with this application to renew registration, the provider had addressed residual failings and the inspector saw that an assisted bath had been installed and the overall resident occupancy was reduced by two with the maximum number of residents accommodated in each bedroom now reduced from three to two.

Overall inspectors were satisfied that the premises was fit for its stated purpose but deficits were identified.

The property is located on a spacious well maintained site and offered pleasing views that many residents commented on as enjoying. Adequate provision was made for car parking; the external grounds were accessible to residents and included an area made safe by a railing.

The premises is a split-level development with residents accommodated on both levels; a lift was provided.

Circulation areas and sanitary facilities were equipped with hand rails and grab-rails and residents had ready access to emergency call facilities.

The works completed to date and the further reduction in bed numbers ensured that the size and layout of bedrooms were suited to the needs of residents. A sufficient number of sanitary facilities all of which were universally accessible were provided for the number of residents to be accommodated.

Adequate provision was made for storage.

Catering facilities were suitably and sufficiently equipped.

Residents had a choice of communal areas and a private space for visitors if required was available on the lower ground floor.

There was a contract for the maintenance of equipment and records seen indicated that equipment such as beds, chairs and pressure relieving equipment was serviced in October 2014. However, not all equipment for use by residents was seen to be in good condition, in proper working order or conducive to effective cleaning predominately bed-tables and bedside lockers.

Areas of the premises particularly at first floor level were well maintained and in good decorative order; the dining and communal areas were welcoming and pleasant.

However, the lower ground level demonstrated some evidence of defective plaster work and scuffed paintwork.

Staff spoken with had a good knowledge of environmental hygiene procedures and had the appropriate equipment provided. However, on the first day of this inspection all areas of the premises in particular floor surfaces were not visibly clean and all areas were not free of unpleasant odours.

While no negative feedback was received from residents or relatives, inspectors were not satisfied as to how the available laundry facilities were adequate. Staff spoken with including the person in charge confirmed that all linen was laundered on site as was the personal laundry of 75% of the residents. There was only one domestic type washing machine and dryer in place. There was some minor evidence on inspection that all bed linen was not replaced/laundered as necessary; information to this effect had also been received by the Authority.

The available dining room did not offer sufficient space for the number of residents accommodated; approximately 50% of residents could be comfortably accommodated and staff confirmed that there was only one sitting for each main meal. Inspectors saw that the remaining residents had their meals served to them on trays where they were seated throughout the day in the main communal area or in the smoking room; this was noted on previous inspections. The person in charge told inspectors that resident's preferred to have their meals in these other areas but in reality all residents could not have exercised the choice to have their meals in the main dining room as there was insufficient space provided.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The centre had a complaints policy in place. The inspectors found that there was a record of complaints. This record included the name of the complainant, the name of the person who took the complaint, the nature of the complaint, the actions taken, and the response of the complainant to the outcome. Residents who spoke to inspectors confirmed that they knew who they could complain to and were satisfied with the arrangements for complaints.

However, a complaint reviewed in detail by the inspectors did not provide adequate detail on the nature of the complaint. The complaint was also noted to be recorded in greater detail in a separate incident book. As such, there was confusion as to how complaints were identified, recorded and managed. Based on the records seen, the inspectors were not satisfied that the complaint in question was handled in a fair and impartial manner and this was discussed in detail in Outcome 7.

The complaints process was displayed but not in a prominent, easily identified place.

The person in charge was the complaints officer and there was an independent person appointed for the purposes of an appeal. The centre had not nominated a second person – other than the complaints officer – to ensure all complaints were appropriately responded to and recorded as required by the regulations.

There was some evidence that there was learning and improvements in the centre as a result of some complaints. For example, there were a number of complaints in relation to food and personal preferences. These complaints were passed on to the kitchen staff and the residents expressed satisfaction with the actions taken.

Judgment:

Non Compliant - Major

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:

Having spoken with staff and reviewed records the inspector concluded that procedures were in place to establish and record residents end-of-life needs, choices and wishes.

Based on a random sample of records the inspector saw that end-of-life care plans were in place and that the plans were made in consultation with the resident and/or their representative as appropriate. The plans were clear and specific to each resident and reflected discussion and agreement on areas such as place of death, the option of a single room, who the resident would like to have present, spiritual needs and active intervention up to and including resuscitation.

There was evidence of improvements made as indicated in the self assessment questionnaire submitted to the Authority early in 2014. As indicated in her response,

training certificates supported that the person in charge had facilitated a number of staff to attend a broad range of related education including end of life communication, palliative care and dementia, and palliative emergencies in the last days of life. Staff spoken with articulated good end-of-life care practice and confirmed that care as necessary was supported by the palliative care team; there were records seen to support this.

However, on speaking with staff it was not evident how the end of life care plan was communicated to staff to ensure that expressed wishes would be adhered to. Staff were not familiar with the plan, specifically in relation to resuscitation decisions and choices. Staff spoken with confirmed that such decisions were not supported by medical discussion and records, as stipulated in local policy.

Judgment:

Non Compliant - Moderate

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

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

Findings:

There was evidence to support that residents were provided with a nutritious and varied diet and processes were in place to ensure that no resident experienced poor nutrition or hydration.

The catering facility was well equipped and there was documentary evidence that it was monitored by the relevant Environmental Health Officer (EHO). The inspector saw varied and adequate stocks of fresh, dry, chilled and frozen foods and meals that were prepared and cooked by staff on a daily basis. The menu offered choice at each mealtime, was clearly displayed and staff were seen to ascertain resident choice. Meals including meals of a modified consistency were appealingly presented; portion sizes were adequate; the inspector saw and residents reported enjoyment of their meals.

The inspector saw that residents had ongoing access to a variety of fluids.

Records seen indicated that there were formal procedures for establishing each resident's dietary choices and preferences and for communicating between staff specific dietary requirements such as swallow care plans. The information seen was clear and current, understood by staff spoken with and there was no evidence to support that

recommendations were not implemented in practice.

A validated tool was used to assess resident's nutritional needs and body weight was recorded monthly or more frequently if indicated. Evidence seen of weight gained indicated that care was delivered as prescribed. Residents with specific needs were seen to have the appropriate nutritional plans of care in place, the plans seen incorporated recommendations from other healthcare services such as dietetics and speech and language therapy and were congruent with the information held by catering staff. There was documentary evidence that the care provided to residents whose nutritional needs were met by the insertion of a tube for feeding directly into their stomach (PEG) was provided in consultation with the appropriate personnel.

The observations of inspectors were that residents were adequately and appropriately supervised and assisted at mealtimes. However, there was an impact on choice and the social dimension of meals due to insufficient dining space and this is discussed in Outcome 12: Safe and Suitable Premises.

Judgment:

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 were regular resident committee meetings. The minutes from these meetings detailed discussions about food, staff and activities amongst other items. The senior care manager chaired the meetings and they were also attended by the activities coordinator.

Inspectors noted a number of visitors to the centre during the course of the inspection. Visitors were seen to be asked to sign in and out and there were no unreasonable restrictions in terms of visiting hours; this was confirmed by relatives surveyed. The centre had a room available for the use of residents who wished to meet with visitors in private. An advocate visited the centre on a regular basis to meet with residents. However, having spoken with the person in charge and reviewed records including incident records, inspectors were not satisfied that the centre understood the concept of

advocacy as supporting, promoting rights, facilitating decision-making, empowering, speaking or acting on a residents behalf particularly in relation to issues of concern to a resident.

Residents had access to religious services and a priest attended to say mass in the centre once a week. Those who could not attend the mass were visited in their rooms by the priest. The activities coordinator also engaged in prayer with residents in their room at their request: religious observance was seen to be of importance and comfort to residents. Staff spoken with were familiar with resident's individual beliefs and confirmed that residents of different faiths were facilitated to travel to their own place of worship.

A number of residents were registered to vote in the centre. Staff and residents confirmed that a returning officer visited the centre in order to allow residents cast their ballot at the time of a local or national vote. Inspectors also noted that residents had access to news and current affairs content via newspapers and television. Residents had access to a landline telephone and inspectors observed a number of residents using personal mobile phones.

An activities coordinator was employed for four days per week and facilitated a range of activities for residents. When the coordinator was not in the centre staff reported the activities were managed by the care staff. Residents met to play games such as cards, charades and bingo. There were also people invited in to the centre to provide activities such as live music, reiki and keep fit. The activities were meaningful and appropriate to the needs and expressed wishes of the residents.

Inspectors observed staff communicating with and caring for residents in a respectful manner. Cleaning staff were observed knocking on bedroom doors before entering a bedroom. However, as discussed in Outcome 7 there was evidence of a problem based approach to residents who displayed or communicated using behaviours that were a challenge to staff.

Inspectors noted that the centre had a number of CCTV cameras in place; signage was in place advising of its use. Inspectors viewed the screen in the nurses' office where the cameras were monitored and found that there were cameras in areas where residents and/or relatives would have had a reasonable expectation of privacy including the dining room and the day room. This matter was raised with the provider on the first day of inspection and action was taken to disable the cameras in question before the close of inspection. The matter of CCTV and privacy had been raised with the provider on a previous inspection by the authority. Initially inspectors were told that there was no policy for the use of CCTV in place but the provider then provided a policy on CCTV to inspectors; however, this required implementation in practice.

While there was evidence of good practice as reported above inspectors were not satisfied that the rights and dignity of each resident were respected and promoted at all times. The findings to support this conclusion are discussed in detail in Outcomes 13 and 7.

Judgment:

Non Compliant - Major

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy in place for the management of residents' personal possessions including financial management; the policy outlined the centres requirements for the issuing of receipts and record keeping.

Residents, including residents in shared accommodation, were seen to be supplied with adequate storage for personal possessions.

The inspector reviewed the systems for managing charges to residents and residents' finances and was satisfied that the systems were transparent and that residents were facilitated to retain control over their own finances. There was evidence of invoices and receipts for services provided to or on behalf of residents; records were seen to be signed by staff and residents. However, the filing of receipts required improvement to ensure that records to support all financial transactions were accurately filed and readily retrieved. This failing was addressed in Outcome 5.

Laundry arrangements have been discussed in Outcome 12.

Judgment:

Compliant

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:

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

No actions were required from the previous inspection.

Findings:

The inspectors were not satisfied that the centre maintained appropriate staffing levels given the number of residents and the design and layout of the centre. The staff roster showed that there were two staff in the centre at night from 01:00hrs to 07:00hrs. The person in charge confirmed this and also stated that the night staff complement had recently been reduced by one. The authority had previously in January 2010 and October 2011 requested the provider to address staffing deficits including night-time staffing levels. The inspectors were not satisfied that the decision to reduce the number of staff at night time was adequately and objectively assessed. The planned rota indicated at times that there were insufficient staffing resources available to respond to contingencies such as sick leave or annual leave. In addition, inspectors were not satisfied that services including the catering facility, laundry and environmental hygiene were adequately resourced. The person in charge advised inspectors that there was an additional staff member allocated to the kitchen for the duration of the inspection. It was noted by inspectors that both kitchen staff were fully occupied for the two days of the inspection. As noted in Outcome 12 areas of the premises were not clean and were not free of odours particularly on the first day of inspection. There was only one domestic type washing machine available to meet the laundry requirements of a 32 bed centre. The inspector noted a schedule of cleaning and laundry duties to be completed by what were already depleted night staff; this would concur with concerns raised with the authority by a concerned person.

There was a nurse on duty at all times in the centre. Regular training was provided to staff on key matters, that is to say, the prevention, detection and response to elder abuse, manual handling and fire safety. However, as discussed in Outcome 7, inspectors were not satisfied that the training on protection was effective. Training records showed additional training completed appropriate to the needs of the residents and to staff member's roles. For example, the kitchen staff had training in the use of chemicals; the nursing staff had training in pain management, insulin administration and wound care; the care assistant staff had training in end of life care, dementia and nutrition and dehydration.

Based on records seen and on speaking with the person in charge inspectors concluded that the system of staff supervision was not adequate and did not ensure that staff were adequately and appropriately monitored (formally and informally), particularly where concerns or areas requiring improvement were identified. Staff files reviewed by the inspectors did not contain regular staff appraisals. For example, one staff member who had been employed by the centre since 2004 had only one completed staff appraisal. Staff meeting minutes seen stated that appraisals would be taking place over the summer months. The person in charge confirmed that these did not in fact take place. Further records of concerns in relation to staff performance and attitude were seen to be recorded in the incident book and it was not clear how these matters were addressed and monitored to ensure the quality and safety of care and services provided to

residents.

The inspector reviewed a sample of staff files and found that two staff nurse files did not contain an up-to-date record of current registration details.

The person in charge confirmed that persons providing services to residents on a regular basis had not been vetted.

Judgment:

Non Compliant - Major

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:

Mary Moore
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 report¹

Centre name:	Sancta Maria Nursing Home
Centre ID:	OSV-0000449
Date of inspection:	05/11/2014
Date of response:	12/12/2014

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 inspection findings found that the management systems did not at all times ensure that the service provided was safe, appropriate to residents needs, consistent and effectively monitored.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The Registered Provider has carried out a review of her roles within the centre, and has engaged of an external consultancy company to assist with the processes. The Registered Provider has appointed a Person in Charge (as discussed on the day of inspection - this plan was in motion prior to the inspection. This has now been finalised).

It is now envisaged that the Person in Charge will take up the post in February 2015 (following completion of the recruitment process), and, the Registered Provider will be ensuring that the Person in Charge has a full and succinct, thorough induction. The Registered Provider will ensure that a complete succession plan will be implemented.

The role of the Person in Charge will be a full-time supernumerary position and the Registered Provider will remain as Registered Provider and will work closely with the Person in Charge at strengthening and building a more robust management team.

The Registered Provider has begun a complete root and branch analysis of the service and will be reviewing how complaints and investigations have been managed to date and does intend to include in the review process and will be examining how previous responses and actions were managed and will identify where the system needs to be improved and developed. The Registered Provider is fully committed to this process.

The Registered Provider will ensure that all centre staff undergo training and development in responding to and managing complaints and concerns raised. The Registered Provider will ensure that the training includes recognising, responding and reporting but also how behaviours that challenge and the actions people take can be viewed as negative and not necessarily in line with best practice.

The Registered Provider will ensure that the measures implemented to protect residents are transparent and clear. The measures to be taken in addressing and managing incidents will be unambiguous, easily followed and easily understood by any person involved in the process. The Registered Provider intends to, that in future the Person in Charge will investigate all allegations of abuse and the Registered Provider, as per SI 415 of 2013, herself investigate should the Person in Charge be the alleged perpetrator.

Proposed Timescale: Review complete by end January 2015, PIC in place February 2015, Staff training to commence early January 2015

Provider's update: (i) The PIC post has been offered & accepted, the new PIC will officially take up post in Feb 2015, the relevant paperwork will be submitted within 10 days of her commencement date, and in the interim the person appointed has commenced the induction programme. (ii) The Terms of Reference for the Review were ratified on the 1st December 2014, and the process has commenced, with a full report/ recommendations to be complete by 1st February 2015. (iii) Abuse/ challenging behaviour training will commence 7th January 2015 & the aim is that all staff will have

attended Abuse training by 31st January 2015 and challenging behaviour training by 28th February 2015. The persons delivering the training, both hold recognised Teaching & Training Qualifications (one is external, has completed the HSE Train the Trainer in Recognising & Responding to Abuse & is an experienced trainer, and the second is an a new staff member, experienced RPN, who hold a Masters Degree in Leadership in Interpersonal Practice, and is experienced in training staff to manage behaviours that challenge. (iv) The policy for Prevention, Protection, Detection and Responding to abuse has been reviewed and amended and will be ratified by 19th December 2014. The Policy clearly identifies the Person in Charge, as the person responsible for investigating allegations of abuse and the RP will investigate or nominate a suitable person, should the PIC be the alleged perpetrator.

Timescale: as above

Proposed Timescale: 28/02/2015

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:

There were 27 contracts available while there were 30 residents living in the centre.

2. 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:

Of the three contracts that were not available, one was a new admission, one was an emergency admission and one was a respite resident.

The Registered Provider will:

- (i) Review the current Admissions Policy in relation to the signing of a contract of care and will ensure that all planned admissions have a copy of a contract prior to admission which will be signed on admission;
- (ii) Create a contract of care which addresses the needs of respite residents;
- (iii) In the case of emergency admissions it might not always be possible/appropriate that a contract is signed on admission but the Registered Provider will endeavour to have a signed contract as soon as thereafter.

The Registered Provider will review the Admissions Policy in compliance with Schedule 5 policies required by the centre.

Proposed Timescale: Contract review and new contract developed, to be agreed and ratified by December end 2014 and to be implemented by 1st January 2015

Provider's update: (i) Contract of Care has been reviewed and ratified & 'new' contracts will be issued to all current residents on 19th December.

The Admissions policy will be complete and ready for ratification on the 19th December 2014.

Timescale: 19th December 2014

Proposed Timescale: 19/12/2014

Theme:

Governance, Leadership and Management

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

Some contracts did not contain the fees payable by residents. There was also a lack of clarity in some contracts in relation to additional fees/charges.

3. Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

The Registered Provider will review the current contract template to ensure that it includes the terms on which the resident resides in the centre, will include the services to be provided, the scheme under which the resident has been admitted, the fees to be charged for additional services, the arrangements for the application or receipt of financial support, the arrangement for the payment or refund of monies and any other services the resident chooses to avail of but which is not included in the nursing home support scheme or which the resident is not entitled under any other health entitlement.

Where applicable, the Registered Provider will re-issue, to residents, a new contract if their current contract does not meet the above requirements.

Proposed Timescale: 31st December 2014 completion of contract, 1st January 2015 re-issue of contracts

Provider's update: Contract of Care has been reviewed in line with regulatory requirements, and 'new' contracts will be issued to all current residents.

Timescale: 19th December 2014

Proposed Timescale: 19/12/2014

Outcome 04: Suitable Person in Charge

Theme:

Governance, Leadership and Management

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

Retrospective actual rotas seen by inspectors indicated that the weekly recorded hours of attendance of the person in charge were inconsistent and at times insufficient.

4. Action Required:

Under Regulation 14(1) you are required to: Put in place a person in charge of the designated centre.

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

As discussed in Outcome 2 the newly appointed Person in Charge will take up post in February 2015. In the interim period, the Registered Provider/Person in Charge will continue to work in the centre predominantly in a supernumerary role as Person in Charge for a minimum of thirty hours per week and will only cover additional nursing shifts where required and is currently in the process of recruiting staff nurses.

Proposed Timescale: PIC – Feb 2015.

Provider's update: A new staff nurse has been recruited and will take up the post in January 2014. The RP/PIC is currently working a minimum of 30 hours in this role.

Timescale: as above

Proposed Timescale: 28/02/2015

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:

Policies on the use of CCTV and the management of accidents and incidents were not adopted and implemented in practice

5. Action Required:

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

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

The Registered Provider will review both policies identified above and will identify which parts were not adopted and implemented in practice, amend if necessary and will ensure that the practices identified in the policies are those adopted and implemented by the centre.

Proposed Timescale: 19th December 2015

Provider's update: (i) Use of CCTV policy reviewed (ii) Accident & Incident Policy currently under review

Timescale: (i) Complete (ii) to be ratified by 19th December 2014

Proposed Timescale: 19/12/2014

Theme:

Governance, Leadership and Management

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

Evidence of current registration details with their regulatory body was not in place for two staff nurses employed.

The person in charge confirmed that a record of the on-going medical assessment, treatment and care of one resident by their GP was not maintained in the centre.

Where it was reported that psychiatric referral and review had been sought and psychological review had been requested, records were not in place to confirm that the reviews had taken place.

Record keeping of receipts and transactions in relation to residents finances required improvement

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:

(i) The current registration details of all staff nurses have been obtained including those that were not available on the date of inspection. The Registered Provider will in future ensure that all staff nurses employed in the centre provide evidence of current registration details and will monitor this by carrying out six monthly review of documents as required per Schedule 2;

(ii) The resident in question chooses to see his GP at the GP surgery and therefore records of his medical care are kept at the surgery as per community practices. If there is occasion for the resident to be seen in the centre the GP maintains a record in the centre. The Registered Provider has written to the GP asking that he provide a duplicate copy of his records that can be kept at the centre;

(iii) The referrals and reviews were done. In order to access psychiatric and psychological services the current system requires that the GP make the referrals and the follow up reviews are provided to the GP. There is no system in place at this time for the centre to be provided with a copy. The Registered Provider has asked the psychiatric consultant involved if copies of correspondence can be provided to the

nursing home. This is not possible. The Registered Provider will request in future copies of all correspondence from GPs and will maintain a written record of this request; (iv) The Registered Provider will review how residents' finances are currently being managed, and will, for the present time, ensure that the receipts are attached to the statements as suggested by the inspector.

Proposed Timescale: (ii) – 1st Dec; (iii) ongoing; (iv) a - by March 2015 and; b – complete.

Provider's update: (ii) Letter sent to GP (awaiting written response)

Proposed Timescale: 31/03/2015

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:

Records demonstrated a problem based approach to residents demonstrating behaviours of a challenging nature. Care plans in place for the management of challenging behaviours were vague; behaviours were not specified, potential triggers were not identified, therapeutic management strategies were not identified.

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:

The Person in Charge has recently employed a very experienced RPN with a solid background in teaching, training and management of behaviours that challenge. The Person in Charge and this nurse will be reviewing (a) how care needs are identified and documented and; (b) will be reviewing the system in place for managing challenging behaviour to ensure that they are clear, concise and are such that the goals and objectives identified are achievable.

The Person in Charge will be implementing the ABC system of identifying triggering challenging behaviours. The new computerised care plan does facilitate this and all entries with regards to behaviour are being monitored.

Proposed Timescale: Challenging behaviour policy - December 2014, training to commence thereafter

Provider's update: (i)The care-plans for residents who present with challenging behaviour have been reviewed and updated (iii) Policy on Behaviour that Challenge has

been reviewed & amended

Timescale: (i) Complete (ii) Challenging behaviour to commence 7th January 2014 (iii) Challenging Behaviour Policy to be ratified by 19th December 2014.

Proposed Timescale: 07/01/2015

Theme:

Safe care and support

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

Records seen did not support that an appropriate assessment of the resident was undertaken by the appropriate healthcare professional to establish the exact nature and aetiology of the recorded behaviours.

Based on the records seen inspectors would not view the actions taken by the provider as reasonable or proportionate.

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:

The Registered Provider is committed to the overall review of the centre's approach to managing challenging behaviours and responding in non restrictive manners. The Registered Provider recognises that there is a need within the centre for a review of the culture as to challenging behaviour. Within this will be a determining of staffs understanding of challenging behaviour and how their actions/inactions can positively/negatively impact on the outcome and consequently on the welfare of residents.

See also actions above.

A part of the review will be a training needs analysis.

Proposed Timescale: Training to commence January 2015, and ongoing afterwards

Provider's update: Review has commenced staff interviews to commence on 6th January 2015 (this is part of the review & will assist in determining staffs understanding & attitudes).

Timescale: Abuse & Challenging behaviour Training to commence 7th January 2015; aim to complete training by 31st January. Review to be complete by 1st February 2015.

Proposed Timescale: 01/02/2015

Theme:

Safe care and support

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

Inspectors were not satisfied that measures in place were sufficiently robust to ensure that residents were at all times protected from harm and abuse.

9. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

The Registered Provider, as detailed above, is looking at the measures that are in place for the protection of residents, and will, moving forward ensure that the systems are sufficiently robust to ensure that residents are protected, as detailed throughout this response. The terms of reference for the review have been agreed and will be ratified by 5th December 2014.

Proposed Timescale: Aim for review to be completed by January 2015.

Provider's update: TOR ratified by 1st December 2014 & process has commenced

Timescale: as above

Proposed Timescale: 01/02/2015

Theme:

Safe care and support

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

Inspectors were not satisfied that complaints made of alleged abusive behaviour were adequately, appropriately, objectively and fairly investigated to transparently support a conclusion by the provider that abusive behaviour did not occur.

10. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

The Person in Charge will, as part of the root and branch analysis, review complaints, will examine how these were investigated and will be accepting of the findings and is committed to ensuring that all future complaints are managed in a fair, open and transparent manner. The conclusions reached by the Person in Charge/Registered Provider will be reflective of good practices.

The Registered Provider will investigate any incident/allegation objectively, with an

acceptance that there can be incidents of abuse which can occur between resident-resident, staff-resident, resident-staff, visitor-resident, external healthcare professional-resident etc.

Proposed Timescale: Ongoing

Provider's update: The review of previous complaints/ concerns & the management of these will be complete by 19th December 2014.

Timescale: 19th December

Proposed Timescale: 19/12/2014

Theme:

Safe care and support

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

The methodology of providing staff training was not adequate to safeguard residents.

11. Action Required:

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

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

The Registered Provider will ensure that staff are trained in the protection, prevention and response to abuse and has arranged for the consultants to work with the RPN/PIC (as previously discussed) to ensure that the training includes challenging behaviours and how management and responses can be viewed as covertly abusive if not well handled.

The Registered Provider will be including in the audit system a mechanism for reviewing self-governance in terms of safety and protection of residents

Proposed Timescale: Training to commence Jan 2015, aim to be complete by April 2015.

Provider's update: (i) Abuse (ii) Audit Tools to be developed

Timescale: (i) Commence 7th January 2015, aim for completion 31st January (ii) Challenging Behaviour Training to commence 7th January and aim for completion 28th February 2015 (ii) Audit tool be complete by 31st January

Proposed Timescale: 28/02/2015

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:

There was no risk assessment in place for abuse as required by Regulation 26 (c)

12. Action Required:

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

The registered provider will put in place a risk assessment for abuse, which will show evidence of risk assessment for mistreatment of a resident by staff, another resident, volunteer/visitor, family or health care professional. The risk assessment will show the measures and actions in place to address the identified risks.

Proposed Timescale: 12th December 2014

Provider's update: Risk Assessment updated
Timescale: (i) complete

Proposed Timescale: 12/12/2014

Theme:

Safe care and support

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

The risk register did not include the arrangements for the identification, recording, investigation and learning from incidents involving residents; a policy was in draft.

13. Action Required:

Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

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

The risk management policy will be reviewed, amended and will include all the requirements as set out in the regulations.

Proposed Timescale: 31st December 2014

Provider's update: The Incident & Accident Reporting policy will be complete by 19th December & the Risk Management Policy complete by 31st December 2014
Timescale: as above

Proposed Timescale: 31/12/2014

Theme:

Safe care and support

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

Any practice necessitating the occlusion of a fire/smoke detector requires review.

14. Action Required:

Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

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

(i) The Registered Provider will, in future, meet with any external contractors prior to the undertaking of any works to identify and discuss with them the works they are going to undertake and the impact this may have on the centre/residents/equipment and put in place measures to control the risks.

(ii) The Registered Provider or most senior nurse on duty will sign off on any works/areas before any external contractor leaves the centre

Proposed Timescale: Ongoing

Provider's update: as above

Proposed Timescale: 31/12/2014

Theme:

Safe care and support

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

One fire escape route at lower ground floor level was obstructed while another deemed suitable on the PEEP for the evacuation of dependent residents had a step up to it and a redundant key box was still in place

15. 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:

Immediate actions taken: the ground floor obstruction was removed and the resident was advised that she should not place personal belongings on the step.

The PEEP for the dependent resident was reviewed and amended and the redundant key box was removed. In future, the Registered Provider will ensure that a daily check

of fire exits is undertaken. This will be monitored by the use of a daily check chart, which identifies each fire escape.

Proposed Timescale: 5th December 2014

Provider's update: Completed

Proposed Timescale: 05/12/2014

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:

Transcribing practice was not in line with local policy or regulatory body guidance.

16. Action Required:

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

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

The current medication management policy will be reviewed with the Pharmacist to ensure that the practices are in line with regulatory body guidance and the PIC will ensure that the practice in relation to the transcribing will be in line with best practice and reflective of the policy.

Proposed Timescale: 31st December 2014

Provider's update: as above

Timescale: 31st December 2014

Proposed Timescale: 31/12/2014

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

A significant deficit was identified in the management of behaviours that challenged including planning care and seeking the appropriate referral and advice.

17. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

As discussed throughout the body of this action plan, the Registered Provider will ensure that the care plans will be prepared in such a manner as to show evidence based nursing and the Registered Provider is currently reviewing all documentation in relation to the management of behaviours that challenge and as previously discussed will be implementing the ABC system of monitoring and recording and would aim to have this part of the review completed by 31st December.

Proposed Timescale: 31st December 2014

Provider's update: Care-plan have been updated and the ABC system will be part of the challenging behaviour training

Timescale: Training to commence 8th December 2014

Proposed Timescale: 31/12/2014

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 available dining room did not offer sufficient space for the number of residents accommodated; approximately 50% of residents could be comfortably accommodated

The lower ground level demonstrated some evidence of defective plaster work and scuffed paintwork.

All areas of the premises in particular floor surfaces were not visibly clean and all areas were not free of unpleasant odours.

Not all equipment for use by residents was seen to be in good condition, in proper working order or conducive to effective cleaning predominately bed-tables and bedside lockers.

There was only one domestic type washing machine and dryer in place to meet the laundry requirements of the service and 75% of residents.

18. Action Required:

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

designated centre.

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

(i) The residents are always accommodated to eat as to where they are most comfortable. The RP does recognise that the dining room cannot accommodate all residents at once, therefore, will have a second sitting if required.

In future, when the staff member takes the residents' order for the meal they will also ask them where they wish to dine.

(ii) The RP has arranged for the staged upgrading/redecorating as required and in future will do monthly walk-about to ensure that this is maintained. The painting works will be completed by 9th January.

(iii) The current system for housekeeping is under review and moving forward the housekeeper will prioritise the areas most requiring attention

Also, the RP has purchased four thermal u/v washroom air purification solution systems which create an infection and odour free environment. These will be installed by 12th December.

(iv) The RP will carry out a full review of all furniture and equipment and has to date purchased a number of new lockers and bedside tables (delivered 28th November). The RP will put in place a cleaning schedule for all equipment. The RP will carry out three monthly health and safety audits, which will include an inspection of all equipment.

(v) The RP has reviewed the current system for laundry and has engaged an external laundry company so that in future all linen will be laundered off-site. Residents' personal laundry will be laundered in-house.

Proposed Timescale: Ongoing

Provider's update: (i) Complete (ii) Painting commencing on the 17th December & will be completed by the 22nd December 2014. (iii) Complete (iv) Health & Safety Audit undertaken on the 11th & 12th December, full report to be available on the 7th January
Timescale: As above

Proposed Timescale: 07/01/2015

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 process was displayed but not in a prominent, easily identified place.

19. Action Required:

Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

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

The complaints procedure is now prominently displayed throughout the centre.

Proposed Timescale: Complete

Proposed Timescale:**Theme:**

Person-centred care and support

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

The centre had not nominated a second person – other than the complaints officer – to ensure all complaints were appropriately responded to and recorded as required by the regulations.

20. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The RP, as part of the overall governance and management review, will be reviewing the current complaints procedures/processes and will ensure that the policy is transparent, user friendly and there are clear stages/people identified.

The RP is currently reviewing the complaints process and the steps within the complaints procedure and will ensure that there is a system in place to ensure that this is fair and impartial. There is a very obvious chain of command and more than one person nominated to deal with complaints.

Once the new PIC is in place the RP and PIC will be the two complaints officers. In the interim the RP and senior nurse will be the two complaints officers.

Proposed Timescale: Complete

Provider's update: Complete

Timescale: As above

Proposed Timescale: 28/02/2015**Theme:**

Person-centred care and support

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

There was confusion as to how complaints were identified, recorded and managed; records were seen in the complaints log and the incident book.

21. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

The new computerised documentation system allows for the recording of complaints and accidents/incidents.

The Registered Provider will also maintain an incident/accident log and will ensure that the requirements of Sch 3, 4(j) are met.

Proposed Timescale: 5th December 2014

Provider's update: All complaints to be recorded in the Epicare system
Timescale: ongoing

Proposed Timescale: 05/12/2014

Theme:

Person-centred care and support

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

Inspectors were not satisfied that a complaint was handled in a fair and impartial manner

22. Action Required:

Under Regulation 34(4) you are required to: Ensure that any resident who has made a complaint is not adversely affected by reason of the complaint having been made.

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

The RP will, in future, ensure that no complainant is adversely affected by the reason of the complaint having been made and will ensure that the follow up and future actions/measures taken are in keeping with best practice, safeguarding and maintenance of the rights and dignity of all involved. As part of the overall governance and management review the investigation and handling of complaints will be a part of this process.

Proposed Timescale: 31st January 2015

Provider's update: as above
Timescale: As above

Proposed Timescale: 31/01/2015

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:

Staff were not familiar with the end of life care plan, specifically in relation to resuscitation decisions and choices. Staff spoken with confirmed that such decisions were not supported by medical discussion and records, as stipulated in local policy.

23. Action Required:

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

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

The PIC will review the policy and will ensure that the policy reflects current practices. The PIC has contacted the computerised care planning company and requested that they amend the profile page to reflect the current resuscitation status of each resident. All nursing staff have access to the profile page as they make entries in the care plan daily. In the interim period and as a temporary measure the PIC will put a discrete list in the treatment room.

The PIC will discuss with the medical practitioners; resident decisions and choices and will discuss with them how they will record this decision and will ensure that any resident who wishes to discuss their decision with the GP is facilitated to do so.

Proposed Timescale: List in treatment room – 5th December 2014. EOLC Policy to be reviewed by 31st December 2014.

Provider's update: List in treatment room complete. The GPs have agreed to document EOLC wishes in medical notes. EOLC Policy updated & ratified

Timescale: Complete

Proposed Timescale: 12/12/2014

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:

Inspectors were not satisfied that the rights and dignity of each resident were respected and promoted at all times. The findings to support this conclusion are discussed in detail in Outcomes 13 and 7.

24. Action Required:

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

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

As discussed in the action plan, the Registered Provider is committed to effectively managing behaviours that challenge and will ensure the use of cctv does not infringe upon the privacy and dignity of residents. CCTVs are only in hallways and external areas.

Proposed Timescale: Ongoing and as above.

Provider's update: as above

Timescale: As above

Proposed Timescale: 28/02/2015

Theme:

Person-centred care and support

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

Inspectors were not satisfied that the centre understood the concept of advocacy as supporting, promoting rights, facilitating decision –making, empowering, speaking or acting on a residents behalf particularly in relation to issues of concern to a resident.

25. Action Required:

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

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

During the training and development programmes as mentioned above re elderly abuse, the Registered Provider will ensure that the programme will also include the roles and responsibilities of an advocate.

Proposed Timescale: Training to commence January 2015

Provider's update: Training to commence 7th January
Timescale: As above

Proposed Timescale: 07/01/2015

Theme:
Person-centred care and support

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

There were CCTV cameras in areas where residents and/or relatives would have had a reasonable expectation of privacy including the dining room and the day room.

26. 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:

The cctv cameras were removed from the day room and smoking room on the day of the inspection. The remaining cctvs are for the purpose of security and are located in corridors and external areas only.

Proposed Timescale: Complete

Provider's update: Complete
Timescale: As above

Proposed Timescale: 12/12/2014

Theme:
Person-centred care and support

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

There was evidence of a problem based approach to residents who displayed or communicated using behaviours that were seen to challenge staff.

27. Action Required:

Under Regulation 09(3)(c) you are required to: Ensure that each resident may communicate freely.

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

The Registered Provider is committed to a person-centered "care need" approach to managing all behaviours, as discussed throughout this action plan.

Proposed Timescale: As discussed above – the care plan review of identified care needs in relation challenging behaviour complete by 31st December.

Provider's update: care-plans reviewed & updated
Timescale: complete

Proposed Timescale: 05/12/2014

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The centre did not maintain appropriate staffing levels given the number of residents and the design and layout of the centre.

Inspectors were not satisfied that services including the catering facility, laundry and environmental hygiene were adequately resourced.

28. 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:

The RP will undertake a review and analysis of current staffing levels using a recognised tool. The RP has reviewed staffing in terms of catering, laundry and environmental hygiene and has, as previously mentioned, outsourced the linen and has put in place a staff member to work from 1am-7am. The role of this person will be as a house-keeper/laundry personnel. The RP has made the decision to have this as a night post so that, for example, the cleaning has as little impact on residents day to day living as possible. This person will clean main corridors, day rooms, communal areas etc. This also ensures that there is a third person in the centre in the event of an emergency or adverse incident.

Proposed Timescale: 12th December 2014

Provider's update: Staffing Level review – complete 12th December
Timescale: Full report to be available 19th December 2014

Proposed Timescale: 19/12/2014

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

The system of staff supervision was not adequate and did not ensure that staff were adequately and appropriately monitored (formally and informally), particularly where concerns or areas requiring improvement were identified.

29. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

The PIC did previously recognise the need for appraisal and does acknowledge that all staff have not had a performance review this year. The staff training and development policy is under review and will include performance review and the RP will ensure that in future the PIC will be responsible for ensuring that reviews occur following probation periods for new staff, annually for other staff, and following any occasion where any staff member is involved in a complaint or disciplinary procedure.

The RP is committed to commencing all appraisals from February 2015 and will have all reviews completed by April 2015.

Proposed Timescale: April 2015. Staff training and development policy by 31st December.

Provider's update: as above
Timescale: As above

Proposed Timescale: 30/04/2015

Theme:

Workforce

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

The person in charge confirmed that persons providing services to residents on a regular basis had not been vetted.

30. Action Required:

Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

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

All persons providing services to residents will have their roles and responsibilities identified and all of these will have Garda clearance.

The Registered Provider has requested a Garda clearance for the hairdresser, chiropodist, and physiotherapist.

Proposed Timescale: Awaiting return of the forms

Provider's update: Vetting forms are being collected and all other external contractors & will be forwarded to the Vetting Bureau as soon as they are returned

Timescale: Aim to have all forms sent to Vetting Bureau by 19th December 2014

Proposed Timescale: 19/12/2014