<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Sancta Maria Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000449</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Gallow's Hill, Cratloe, Clare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>061 357143</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:sanctamarianursinghome@gmail.com">sanctamarianursinghome@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Olivia English</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Olivia English</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Moore</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Louisa Power;</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>31</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>11 June 2015 09:30</td>
<td>11 June 2015 21:30</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 14: End of Life Care</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection

This inspection was the eighth inspection of the centre by the Authority and the third following the provider’s application to the Chief Inspector for renewal of registration of the centre. The purpose of this inspection was to follow-up on the findings and the provider’s response to the action plan from the last inspection of the 8 and 9 April 2015. That inspection covered thirteen outcomes from which there were eight outstanding actions including an immediate action plan to address failings in medication management systems and practice.

The provider had addressed three actions; measures to safeguard residents, staff training and food safety; had substantially addressed another, complaints management but was found to be in major non-compliance with four, three of which are considered core outcomes by the Authority; medication management, healthcare and governance.

There were repeated concerning failings in medication management systems.

Based on the records available to inspectors and staff spoken with, inspectors had
concerns that appropriate medical and healthcare including a high standard of evidence based nursing care in accordance with professional guidelines was not in place for all residents at all times.
Outcome 02: Governance and Management

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

Theme:
Governance, Leadership and Management

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

Findings:
The provider and person in charge confirmed that they were in regular almost daily contact with each other and held formal monthly meetings; records were in place to this effect.

A schedule of audits was commenced in January 2015 to collectively inform the annual review of the quality and safety of care as required by Regulation 23 (d). Quality improvement plans accompanied each audit.

While improvement was evident inspectors were not satisfied that management systems at all times ensured that the service and care provided to residents was safe, appropriate and responsive to residents needs, consistent and effectively monitored. The evidence to support this judgement was the repeated serious and concerning failings in; medication management systems, inadequate facilitation of timely medical review and care, and the failure to maintain adequate records including nursing records.

These are discussed in detail in the relevant outcomes.

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

**Findings:**
A record of each medication administered, signed and dated by the nurse administering the medication was not always maintained in accordance with professional body guidelines.

An adequate and accurate nursing record of the person’s health, condition, treatment given, discussions held and changes made was not at all times maintained.

A record of on-going medical assessment, treatment and care provided by each resident’s General Practitioner was not accurately maintained.

Following a resident’s return to the designated centre from another hospital all relevant information about the resident, their care and treatment was either not in place, incorrectly filed or not available at the time of inspection.

All of these failings are discussed again in the relevant outcomes.

**Judgment:**
Non Compliant - Major

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

**Findings:**
The outstanding actions had been addressed.

The registered provider revised and amended the policy for the prevention, detection and response to any alleged, suspected or reported abuse. The policy now clearly differentiated between a complaint and an allegation of abuse and directed staff as to how to analyse and categorise any information received.

The policy set out and clarified for staff the requirement of them to record any suspected or alleged abuse brought to their attention; a reporting template was available as outlined in the provider’s response to the action plan.

Recently recruited staff had received training on both safeguarding and responding to behaviours that had the potential to challenge.

Both the provider and person in charge confirmed that there was no incident of alleged, suspected or reported abuse.

Inspectors met with residents and were reassured that there were no ongoing issues of concern or worry.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
Both the registered provider and the person in charge told inspectors that the relevant Environmental Health Officer (EHO) was satisfied with the practice of allocating staff whose primary responsibility was environmental hygiene to the catering department at peak activity times on the basis that the practice was risk assessed and appropriate controls were identified and implemented.

A risk assessment was in place that set out the required controls including no participation in food preparation, hand-washing and the use of personal protective equipment.

Judgment:
Compliant
### Outcome 09: Medication Management

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

**Theme:**
Safe care and support

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

**Findings:**
The centre-specific policies on medicines management had been reviewed in May 2015 and were made available to inspectors. The policy was comprehensive and evidence based. Staff with whom inspectors spoke demonstrated an awareness of the policy; however failings identified in practice indicated that policy was not always implemented.

Inspectors noted that medicines were stored in a locked cupboard or medicines trolley. Medicines requiring refrigeration were stored appropriately. The temperature of the medication refrigerator and storage areas were noted to be within an acceptable range; the temperature was monitored and recorded daily.

Medicines for residents were supplied by a community pharmacy. Medicines were supplied in compliance aids, identifiable information for medicines was available and the pharmacist supplied a record of the medicines dispensed with the aids. However, the inspectors observed a compliance aid where the record supplied did not accurately reflect the contents of the compliance aid. While policy stated that all medications supplied were to be checked against the compliance aid insert and the prescription this error was not identified during the checks to be made by staff on receipt of medicines. Therefore, staff did not have an accurate record of medicines within the compliance aid in order to cross-reference and administer in line with the prescription.

Inspectors noted two significant errors relating to the supply and management of controlled drugs. Inspectors observed a recent receipt of controlled drugs that did not maintain a robust chain of custody as per the Misuse of Drugs Regulations. The controlled drugs register was not accurately maintained; the stock balance was incorrect and had not been identified at change of shift stock balance checks.

The person in charge confirmed that the practice of transcription had ceased as specified in the providers response to the action plan. However, the inspector observed a number of spelling errors and ambiguous prescriptions which had not been clarified prior to administration of the medicine.

The inspector reviewed a sample of prescription records. Where medicines were to be administered in a modified form such as crushing, this was individually prescribed by the medical practitioner on the prescription chart. However medications that were available in alternate format (liquid) were also seen to be administered crushed.
Based on a sample reviewed, inspectors noted that medication administration records identified the medicines on the prescription sheet and allowed space to record comments on withholding or refusing medicines. However, inspectors saw that a record of each drug and medicine administered signed and dated by the nurse adminstering the medication was not consistently maintained. Prescribed nutritional supplements were also not recorded as administered.

Staff reported that medicines which were out of date or dispensed to a resident but were no longer needed were stored in a secure manner, segregated from other medicinal products and returned to the pharmacy for disposal. However, inspectors saw numerous topical preparations in residents’ bedrooms and in communal bathrooms that were beyond their expiration date.

As indicated in the provider’s response to the action plan inspectors saw that there was a system in place for reviewing and monitoring safe medicines management practice. Errors were identified including prescribing errors, dispensing errors and recording errors. However, as outlined in these findings the audits were not sufficient to identify all pertinent deficiencies and it was unclear how errors provided an opportunity for ongoing improvement and robust, safe practice.

**Judgment:**
Non Compliant - Major

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

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

**Theme:**
Effective care and support

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

**Findings:**
Inspectors reviewed in detail the nursing and medical records of seven residents (22%) each of whom had been admitted to the acute hospital services, some by way of accident and emergency, in the nine weeks prior to the inspection. Inspectors had concerns that appropriate medical and healthcare including a high standard of evidence based nursing care in accordance with professional guidelines was not in place for all of these residents.
Nursing records indicated that a resident with complex health needs when assessed and recorded as “drowsy” with reduced responsiveness did not have their vital signs (temperature, pulse, blood pressure) or blood sugar levels monitored by nursing staff and these were only assessed following consultation with the out of hours medical service almost four hours later; the resident was then recorded as having a raised temperature and an seriously elevated blood sugar reading (hyperglycaemia) of 33.2mmols/l. The World Health Organisation (WHO) defines non fasting hyperglycaemia as 11:00mmols/l. The resident’s care plan did not outline the frequency for blood sugar monitoring; the plan advised staff to observe for signs of hyperglycaemia.

Inspectors were concerned in relation to the nursing implementation of intermittent urinary catheterisation for a female resident in March 2015 without any evidence to support the appropriate assessment, investigation and rationale for the nursing diagnosis of retention of urine. Following several recorded requests from nursing staff for medical review from the 23 April 2015 the resident was, based on the records seen, reviewed on the 6 May 2015 and transferred to the accident and emergency department.

It was of further concern to inspectors that intermittent catheterisation reverted to continuous catheterisation over a four day period due to an inadequate supply of catheters as recorded by nursing staff; the resident pulled out the catheter on the fourth day.

Inspectors were not satisfied that adequate measures were in place to identify and manage compromised dietary and fluid intake. Staff spoken with confirmed that records of dietary intake and records of fluid intake and output were not maintained though these were identified interventions in nursing plans of care seen. One nursing record for a resident with a known pattern of lack of appetite and refusal of food stated that catering staff reported that a resident had refused food and fluids for three days with no evidence of intervention over the previous three days; the resident was admitted to the acute services via ambulance. Inspectors were advised that this was not an accurate nursing record. In line with regulatory body guidelines it is reasonable for inspectors to assume that every nursing record is an accurate and factual record of care delivered.

A dietician was informed by nursing staff that a resident was not on prescribed oral nutritional supplements; however, the resident did have a prescribed and administered nutritional supplement as seen by inspectors on the relevant medication records. The dietician’s recommendations were therefore based on incorrect information.

There was inconsistent and inadequate monitoring and recording of bowel movements. One care plan outlined the use of an enema that was not prescribed. A resident required hospitalisation due to the adverse effect of loose stool on prescribed medications; nursing records indicated that laxatives had been administered to the resident on the days prior to hospitalisation.

All relevant information in the form of a discharge letter about the resident, their care and treatment following their transfer to and discharge from the acute services was not available to inspectors for three residents at the time of the inspection. The nursing record of the resident’s health and condition on readmission was not always adequate;
one in relation to a resident with complex needs (post surgery resident) referred only to the status of the resident’s pressure areas.

Medical records were computerised and each GP was facilitated with an individual log in. However, it was impossible for inspectors to be definitive in some cases as to the frequency, timeliness and appropriateness of medical review and care as this system was not consistently enforced. Nursing staff made consistent, regular and frequent entries into the medical records rather than the nursing progress notes and when a GP did not log in themselves their entry also appeared as recorded by a member of the nursing team.

As on previous inspections it was reiterated to the provider that notwithstanding any reported difficulties in facilitating residents to access services it was the providers legal responsibility to provide to each resident the appropriate medical and healthcare required to meet their needs.

Judgment:
Non Compliant - Major

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

Findings:
The actions necessary from the last inspection were substantially addressed.

The complaints policy had been revised and amended; the policy identified the complaints officer, the appeals process and the person responsible for ensuring that all complaints were appropriately responded to and that the required records were maintained.

The remaining staff had completed complaints management training.

The registered provider articulated responsibility for the previous poor management of complaints and the negative consequences of this. The registered provider articulated learning and reassured inspectors that there would be no reoccurrence of poor practice.

Inspectors reviewed the complaints log and two complaints were logged since the previous inspection. There was evidence that complaints were listened to, failings that
led to the complaints were acknowledged, corrective actions were identified and reassurance provided to the complainant. However, the records did not detail the findings of investigation and the final actions taken to resolve the complaint; it was only on speaking with staff that it was clear to inspectors what the findings were and what action was taken to resolve the matters complained of. The complaints were prematurely closed off as resolved.

Judgment:
Substantially Compliant

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

**Findings:**
This action was not met and all discussions were not documented as outlined in the provider’s response to the action plan.

Residents did have end of life care plans and those seen were person centred and reflected expressed choices and preferences such as who they would like to have present as end of life was imminent. Inspectors reviewed at random three explicit instructions to do not attempt resuscitation; it was recorded in each care plan that each resident did not wish to be resuscitated.

However, decisions to attempt or not resuscitation were not clearly and accurately documented, along with how the decision was made, the date of the decision, the rationale for it and who was involved in discussing the decision. Only one of these three decisions was seen to be supported by a dated record of discussion between the resident and their GP. Nursing staff said that they had had a discussion with medical personnel in relation to another one of these decisions but had not recorded this discussion.

**Judgment:**
Non Compliant - Moderate

**Outcome 18: Suitable Staffing**

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

Theme:
Workforce

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

Findings:
These actions were addressed.

All nursing staff regularly employed in the centre including the registered provider and the person in charge had completed medication management training and an assessment of medication management competency. However, in the context of the ongoing failings in medication management it was difficult for inspectors to be assured as to the learning acquired.

The remaining and outstanding staff at the time of the previous inspection had completed complaints management training.

Judgment:
Compliant

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
Centre name: Sancta Maria Nursing Home
Centre ID: OSV-0000449
Date of inspection: 11/06/2015
Date of response: 26/08/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems did not at all times ensure that the service and care provided to residents was safe, appropriate and responsive to residents needs, consistent and effectively monitored.

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

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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:
There has been a change in the Management of the Centre as notified to the Authority on the appropriate notification form, the Registered Provider is also now back in the Person in Charge Role on a full time basis until an appropriate replacement is recruited. She has substantial support in both roles from the Deputy Person in charge who also works full time in the Centre.

She is fully committed to the overall Governance and Management of the Centre and has a very clear knowledge and understanding of the legal responsibilities pertaining to both Roles.

She will continue to complete a regular schedule of Audits and reviews in order to maintain continuous improvement in all aspects of the service. A high level of supervision will be maintained to ensure a high quality of care is provided across all areas of Health and Social Care needs.
Her priority is to ensure each resident is provided with safe and appropriate Health and Social care needs. Identified failings will be dealt with in order to achieve full compliance. The RP/PIC acknowledges previous failings and has learned from same.

Providers Updated Response:
The RP/PIC has been in contact with a recruitment agency but to date has not found a suitable Person in Charge; while awaiting confirmation of registration with the Authority the RP will continue to work as the PIC of the centre. She has continued support of the DPIC in this role and joint ownership of the management and supervision of the centre is working well at present.
If and when any changes are made to the management structure of the centre the Chief Inspector will be notified on the appropriate NF form.

Both the PIC and the DPIC are satisfied that the current arrangement is providing safe and appropriate Health and Social care needs to all our residents. Audits and reviews are ongoing in order to reach effective compliance with Regulations and standards

Proposed Timescale: COMPLETE

Proposed Timescale: 26/08/2015

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:
The records listed in Schedule 3 in respect of each resident were not maintained in such a manner so as to ensure completeness, accuracy and ease of retrieval.
2. **Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
The RP/PIC acknowledges that on the day of inspection Inspectors could not be provided with discharge letters for 3 Residents. One of the residents had only been reviewed in A&E and not admitted therefore there was no discharge letter received as she had not been admitted to the service. Verbal information had been received for the resident Next of Kin in relation to her treatment while in A&E, however the RP/PIC acknowledges that this is not acceptable and will take all reasonable measures going forward to ensure same is obtained to provide effective and appropriate care.

The second resident in question – due to poor filing the discharge letter was not available to Inspectors on request, Same was found after the inspectors had left and emailed to the inspector the following morning. The filing system has now been improved to ensure no re-occurrence of same.

The third letter was provided to the inspectors while on site however the RP acknowledges that there was difficulty in retrieving same in a timely fashion and has updated the filing system to prevent reoccurrence.

In relation to medication administration sheets weekly audits of same will continue, inaccuracies will be recorded as incidents/medication errors in order to highlight, promote awareness of errors and encourage adherence to policy and An Board Altranais guidelines on Medication Management (Further discussed in outcome 9).

The RP/PIC recognises that records set out in Schedule 3 were not accurately maintained. Since the inspection she has given each staff nurse a copy of the schedule 3 records to be kept in a designated centre in respect of each resident to ensure compliance is maintained in this area. A copy of the An Board Altranais guidelines on Documentation in Clinical Practice has also been circulated to all staff nurses. Follow up training in this area is to be provided by an external trainer. A provisional date of the 27.08.2015 has been arranged, to be confirmed when all Nursing Staff have returned from annual leave.

Medical records
Inspectors concern regarding ongoing medical assessment is discussed in outcome 11

Providers Updated Response:
A training workshop in Documentation in Clinical Practice is taking place on 27/08/15 and as many Staff Nurses as possible are to attend same. For those who cannot attend due to scheduled duty the PIC will brief and update them on best practice in this area in line with An Board Guidelines and HIQA standards.

Any resident who has been admitted/readmitted to the centre in the last 9 weeks has full discharge information available for inspection in their individual files.

Weekly auditing of Medication Administration sheets is ongoing, with one documented incident in the last 9 weeks which had no adverse effects on any resident.

We continue to work closely with GP’s in order to ensure ongoing medical assessments
Outcomes 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:
A recent receipt of controlled drugs did not maintain a robust chain of custody as per the Misuse of Drugs Regulations. The controlled drugs register was not maintained accurately.

3. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
The RP/PIC recognises the discrepancies noted in relation to controlled drugs and acknowledges the potential risk which could occur in the event that the controlled drug register is not accurately maintained. The two Nurses involved in the discrepancies noted by the inspectors acknowledge their failings to accurately maintain the register of controlled drugs.
Both nurses involved in this inaccuracy are fully aware of their responsibility to maintain a robust chain of custody and recording and unfortunately on this occasion human error supervened. One nurse made a subtraction error and the other did not co-sign and date a delivery of one resident’s medication. The RP also acknowledges her failings that a robust supervision of the controlled drugs recording was not effectively maintained. All nursing staff have been re-briefed on the importance and severity of potential risks occurring if an appropriate maintenance and robust chain of custody is not followed. In order to prevent reoccurrence of the identified documenting errors the controlled drugs register as well as the stock balance check book and the stock itself are now checked at the change of each shift and same is monitored daily by the PIC.
No errors in relation to controlled drugs have been noted since the inspection.

Providers Updated Response:
Robust supervision continues over the management of Controlled Drugs and no further discrepancies have been noted to date. One member of staff has completed a Study Day on Medication Management provided by Nursing Homes Ireland and remaining Staff Nurses are to have a further training workshop on 27/08/15

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

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not have an accurate record of medicines within the compliance aid in order to administer in line with the prescription.

Ambiguous prescriptions were not clarified prior to administration.

A record of each drug and medicine administered signed and dated by the nurse administering the medication was not consistently maintained. Prescribed nutritional supplements were not recorded as administered.

Topical preparations in residents’ bedrooms were beyond their expiration date.

Audits were not sufficient to identify all pertinent deficiencies and it was unclear how errors provided an opportunity for ongoing improvement and robust, safe practice.

**4. 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 RP takes full responsibility for not having the record of medicines within the compliance aid replaced in a timely manner she herself had checked in the delivery and had recognised the discrepancy of the medicine within the tray but had verified that it did contain the correct medication. Unfortunately due to familiarity and oversight she did not have the cassette insert corrected. A correct cassette insert was provided prior to the inspectors leaving.

In relation to ambiguous prescriptions the nursing staff have been consulted re same and did not feel that any prescriptions were ambiguous to them, However we acknowledge the importance of clarifying any prescriptions that may be unclear with the prescribing Doctor prior to administration of Medication. We do acknowledge that spelling errors were present but these were in the form of one letter missing or an incorrect letter – which the staff recognised as possible typo errors. Particular attention will be made to these going forward and we will endeavour for G.Ps to correct same if they occur.

As mentioned in outcome 5 medication administration sheets will be continued to be audited on a weekly basis and identified errors/near misses recorded as incidents. In the instance of nutritional supplements not been signed for the resident in question had been refusing same but staff had not adhered to policy by placing an “R” in the time slot to indicate refused nor had they given a rationale for refusing, the resident did have a care plan in place for refusal to comply with prescribed medication. The
resident’s supplements have since been changed in consultation with his G.P to a brand that is more amenable to him. All staff nurses have been advised to refresh on An Board Altranais guidelines on Medication Management and refer back to local policy to ensure effective compliance; further training is to be delivered by an external trainer with a provisional date set for the 27/08/2015 to re enforce prior learning and importance of adhering to An Board Altranais guidelines. Staff nurses have been advised that repeated errors will lead to disciplinary action.

Out of date topical moisturising preparations were removed following the inspection and staff have been advised to check expiry dates on moisturisers and any other topical preparation prior to applying same.

Audits will continue on medication management but the RP/PIC intends to involve all nursing staff in the auditing process in order to expose them to the identified errors to provide a clear understanding and re enforce the need to learn from errors / near misses, a team approach will be taken to the auditing process going forward.

Providers Updated Response
Scheduled weekly audits are ongoing in relation to Medication Management. Audits include checking of Drug Cardex against Cassette contents and Cassette contents descriptions on delivery as well as by individual nurses on administration. Each Nurse is also aware of the importance of ensuring that all prescriptions are clear and without ambiguity. All Nurses have been instructed to seek clarification from the prescribing Doctor and Pharmacist if any element of the Medication Management Process/Cycle is unclear prior to administering any Medication. Pharmacy are involved in the checking and clarification of any new Prescription issued prior to dispensing the medication for the Resident.

One member of staff has to date completed A Medication Management Study Day, the majority of the remaining nursing staff are to complete further training on 27/08/15.

No further spelling errors have been found since the last inspection.

The checking of expiry dates on all topical preparations has become a daily practice.

Proposed Timescale: 27/08/2015

Proposed Timescale: 27/08/2015

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 purposeful sample (22%) of nursing and medical records reviewed indicated that appropriate medical and healthcare including a high standard of evidence based nursing
5. **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:**
All care plans are to be reviewed to ensure reference is made to best practice in line with An Board Altranais guidelines. The RP/PIC intends to liaise with Clinical Nurse Specialists where available to ensure the most up to date best practice guidelines are adhered to, She has already begun to liaise with a Diabetic Nurse Specialist in order to achieve best practice in the care and treatment of Residents with Diabetes. Nurse specialist services are limited but the RP/PIC will endeavour to make best use of the resources available to her. (Ongoing)

Interventions identified in care plans and relevant documentation are now being maintained and monitored to ensure the relevant treatment is identified and delivered. Outcome of inspection has been discussed with all Nurses and failings identified and acknowledged and a back to basics approach adopted in relation to assessment and implementation of care in line with best practice in a timely and efficient manner.

In relation to Medical Records the RP/PIC acknowledges the inconsistency in Medical notes due to Staff Nurses recording in the medical tab in Epic. The GP’s who did not have an individual log in code have now been assigned same and advised of the importance of using their individual log in codes for identification purposes. The practice of Nurse recording in the medical tab in Epic care has now ceased, Nurses will only record in the Nursing Progress notes to avoid confusion.

**Providers Updated Response:**
Care plans remain under regular review to ensure a high standard of evidence based nursing care is provided to all residents. Reviews/evaluations are now visible in the progress notes for ease of retrieval due to an upgrade in the EPICCARE system

The Diabetic Nurse Specialist have proved to be an excellent resource in providing best practice guidelines in the management of residents with diabetes. Other Nurse specialists have limited; however they will provide general advice over the phone if required.

Relationships with other disciplines remain strong with regular input into residents care and care planning from Dieticians, Occupational Therapists and SALT.

Letters have been written to GP’S that have not responded to phone request to review residents with effect.

Nurses continue to refrain from recording in the medical tab of EPIC this is exclusively for doctors and nurses notes continue to be maintained in Daily Progress section.
Proposed Timescale: COMPLETE

Proposed Timescale: 26/08/2015
Theme:
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Following a resident’s return to the designated centre from another hospital all relevant information about the resident, their care and treatment was either not in place, incorrectly filed or not available at the time of inspection.

6. **Action Required:**
Under Regulation 25(2) you are required to: On the return of a resident from another designated centre, hospital or place, take all reasonable measures to obtain all relevant information about the resident from the other designated centre, hospital or place.

**Please state the actions you have taken or are planning to take:**
All reasonable measures will be taken going forward to ensure all relevant information about residents on readmission from hospital or another assigned centre is received and filed appropriately for easier retrieval. The current filing system has been reviewed to facilitate same.

Providers Updated Response:
6 Residents were admitted /readmitted from Rehab and the Acute services in the last 9 weeks and all have full discharge information available on file.

Proposed Timescale: Complete

Proposed Timescale: 26/08/2015

**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:**
Complaint records did not detail the findings of investigation and the final actions taken to resolve the complaint; complaints were prematurely closed off as resolved.

7. **Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.
Please state the actions you have taken or are planning to take:
In one logged complaint the inspectors noted that how the complaint was resolved had not been recorded. The complaint had in fact been satisfied but the RP acknowledges that the complaint had been closed prematurely without all the relevant details being recorded. She will ensure that there is no reoccurrence of same and that policy is adhered to and the appropriate guidelines of reporting and recording are followed.

Providers Updated Response:
There have been no complaints since the last inspection but all staff are aware that a recorded complaint can only be closed off by the RP once she is satisfied that same has been resolved and the complainant satisfaction is confirmed.

Proposed Timescale: Completed

Proposed Timescale: 26/08/2015

Outcome 14: End of Life Care

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Decisions to attempt or not resuscitation were not clearly and accurately documented, along with how the decision was made, the date of the decision, the rationale for it and who was involved in discussing the decision

8. 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:
In order to fully comply with Regulation 13(1)(a) the RP/PIC has devised a form to be signed by residents, a member of the nursing staff and the residents G.P to reflect their decision post information on resuscitation using the National consent policy, Part 4 DNR. (Completed)

Further consultation with residents and G.P's is required to complete this form and same will be filed in resident’s individual file.

Providers Updated Response:
Each resident has a comprehensive end of life care plan in place containing as much information as the resident is willing to give in relation to their end of life care. All current residents have a Resuscitation decision on file which has been signed by the resident, the GP and a nurse. The rationale for the decision is also recorded on this form.
Proposed Timescale: Complete

Proposed Timescale: 26/08/2015