### Health Information and Quality Authority Regulation Directorate

**Compliance Monitoring Inspection report**

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Fatima Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000264</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Oakpark, Tralee, Kerry.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>066 712 5900</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@fatimahome.com">info@fatimahome.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>Dominican Sisters</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Sr. Teresa McEvoy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>64</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.

▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following an application to vary registration conditions. 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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<tbody>
<tr>
<td>07 January 2016 08:50</td>
<td>07 January 2016 17:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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**Summary of findings from this inspection**

This report set out the findings of a follow up inspection of Our Lady of Fatima Home which took place on the 07 January 2016 by the Health Information and Quality Authority’s Regulation Directorate. The provider had applied for a variation to their conditions of registration and had applied to register nine new bedrooms which were to replace a current six bedded ward and three twin rooms were to be converted to single rooms. The new rooms were in a purpose built wing which contained nine large single en-suite rooms, a sluice room, storage rooms and a nurses station. The overall number of residents in the centre were to remain the same. As part of the inspection the inspector met residents, relatives, the provider, the person in charge the assistant director of nursing, nurses, care, household and catering staff. The inspector observed practices and reviewed documentation such as care plans, medical records, training records, staff files, the complaints and incidents log and relevant policies.

The centre underwent a monitoring inspection on the 21 July 2015 and the
inspectors found that improvements were required to maintain a safe environment for residents and in infection control processes in the centre. On the day of that inspection an immediate action plan was issued to the person participating in management regarding inadequate controls to prevent the risk of fire in the centre due to inadequate arrangements to safeguard a resident while smoking. A satisfactory response was received by the close of the inspection. Actions were also required in the areas of Health and Safety and Risk, premises, Medication Management, staffing and care planning. On the previous inspection out of the 12 outcomes inspected there were two outcomes compliant, seven outcomes were non-compliant moderate and three outcomes found to be non-compliant major. Major non-compliances were found in premises health and safety and medication management. All of these actions were looked into on this inspection and the inspector found that although the majority of actions were completed or partially completed there continued to be non-compliances in care planning, restraint practices and in the provision of an annual review.

The action plan at the end of the report identifies the improvements that were required to comply 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.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

Theme:
Governance, Leadership and Management

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

Findings:
On the previous inspection it was identified that at the weekend and at night-time it was unclear who was the accountable person when the senior management team were off duty. It was deemed to be the most senior nurse on duty however, this person was not named or identified for each shift. On this inspection this person was identified on the off duty.

On the previous inspection the handover of information which occurred every morning took place in a sitting room in the centre and was attended by all staff however, this arrangement meant that some units were left unmonitored. Inspectors formed the view that this method of communication posed a potential risk to residents in the centre. On this inspection the inspector saw and was informed that this practice had stopped. The nurses took the handover from the night staff centrally and then came back to the individual units to give handover to the care staff. This ensured that there was effective communication and handover of important information whilst maintaining supervision of the units.

There was evidence of regular audits conducted in the centre in the areas of care plans, falls, dysphagia, incontinence and medication. Actions were identified as a result of these audits and these actions formed the basis for further re-audit to ensure implementation. However, on the previous inspection there was no annual review of the quality and safety of care and the quality of life of residents in the centre as required by Regulation 23. On this inspection the inspector saw that since the last inspection the provider and person in charge had undertaken a survey of the quality of life of residents in the centre with the residents and family and there was evidence of actions taken in relation to the feedback from same. There were regular reviews of accidents and incidents and ongoing audits. However all this information was not formulated into an
overall annual review of the quality and safety of care and the quality of life of residents in the centre as required by Regulation 23 therefore this action was not completed and the provider remained non compliant.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
On the previous inspection the copy of the Statement of Purpose made available in the main reception of the centre was not the most up to date version, as required by Schedule 4, as it was dated 2012. On this inspection the update statement of purpose was available.

On the previous inspection the inspectors viewed a sample of staff files and found that not all the requirements of Schedule 2 of the Regulations were in place. Not all staff had outlined a full employment history and a vetting disclosure from an Garda Siochana was not in place for a new member of staff. On this inspection the inspector reviewed a sample of staff files and found that the sample of files met all the requirements of schedule 2. The person in charge said they had undertaken a full review and audit of staff files and the inspector saw evidence of same.

On the previous inspection there were two further actions required one was in relation to recording in residents records and the other in relation to recording practices in medication management. These actions will be discussed under the relevant outcomes which are outcome 11 Health and Social Care Needs and outcome 9 Medication Management.

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

**Findings:**
The centre had an up to date policy for the prevention, detection and response to abuse. Staff spoken with were knowledgeable on what action to take in the event of an allegation of abuse. Residents and visitors spoken with said that they felt safe in the centre. However on the previous inspection staff training on elder abuse was out of date as it had not taken place since 2012 and there were some staff who had not received elder abuse training in the centre. On this inspection the inspector saw and staff confirmed that staff had received updated training in elder abuse detection and prevention on various dates in September and October 2015. Staff from all areas caring, catering, household, laundry and administration staff were included in the mandatory training.

On the previous inspection the inspectors reviewed the systems in place to protect residents’ finances and found that a robust system was in place to document the payment of fees by residents and receipts for additional charges such as physiotherapy, hairdressing and chiropody were seen. The centre kept documentary evidence of money paid into and out of residents’ petty cash funds. However, as required by Schedule 3(5)(b)(i) the purpose for which money was used was not always documented for each transaction where applicable. On this inspection the person in charge said they had implemented a new system whereby the resident also signs where possible and all items purchased are documented and this was confirmed to be the case.

On the previous inspection the centre had an up to date policy on the management of behaviours that challenge. However, not all staff had training in behaviours that challenge in the centre in order to meet the needs of the residents. On this inspection training records viewed by the inspector confirmed that training on preventing and responding to behaviours that challenge was provided to staff on a number of dates in September and December 2015 with a further staff booked for this training in January 2016.

On the previous inspection the inspectors reviewed the documentation informing the use of bed rails in the centre and found that the practice in place in the centre regarding the documentation of the details of the restraint in use (time-frames, duration, monitoring of bed rail use) was not in line with the centres policy on restraint or with national policy. The restraint review and release charts which were required to be
completed on a daily basis had not been completed over the previous 3 weeks for one resident. On this inspection the inspector saw that restraint review and release forms had been completed. The person in charge assured the inspector that they actively working to reduce the number of bed-rails in use and had purchased a number of low beds which the inspector saw in use during the inspection. The inspector saw that the centre was accepting consent for the use of bed-rails from family members for the use of restraint, this practice required review as legally consent cannot be given for an adult. Best practice guidelines state it should be discussed with family but the resident themselves is the only person who can consent.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The centre had an up to date Health and Safety statement in place. On the previous inspection the inspectors saw service records for fire equipment (fire extinguishers, fire blankets, fire hoses, emergency lighting, fire doors). Daily and weekly checks of fire equipment and escape routes by staff were documented. The fire alarm system had recently been serviced (June 2015). Records of regular fire drills were seen, however the inspectors found that there were a number of issues identified with fire compliance which included not all staff having received up to date training in fire safety on this inspection the inspector saw that staff had attended fire training on a number of dates from July to October 2015. On the previous inspection the centre did not have personal emergency evacuation plans in place for residents and some fire doors were seen held open with door wedges.

On this inspection the inspector viewed personal evacuation plans in all resident's records which identified their requirements in relation to their evacuation in the case of fire. There was no evidence of any door wedges used on fire doors on this inspection.

On the previous inspection an immediate action plan was issued to the person participating in management in relation to a resident smoking in their bedroom. Inspectors were also informed that there was the additional risk to this arrangement in that an oxygen cylinder was also stored in this resident’s bedroom. In addition, this resident was not supervised when smoking and this residents’ smoking risk assessment had not been updated to reflect this unsafe arrangement. The person participating in management took immediate action in relation to this issue. There was also a smoking room in the centre where cigarettes and ash were disposed of in an ashtray stored on a
shelf. This arrangement posed a risk of fire if the ashtray fell from the shelf and the room contained flammable items such as books and soft furnishings. This room was also used as the centre’s shop storing confectionery and other toiletries which may have been flammable. On this inspection the inspector saw that all flammable items were removed from the smoking room. Fire Buckets filled with sand had been implemented to dispose of cigarette butts and a new ventilation system installed. The person in charge and staff assured the inspector that since the last inspection there were no residents smoking in their rooms and residents only smoked in the smoking room.

On the previous inspection linen stores containing plastic aprons, and sluice rooms containing chemicals were found to be open posing a risk of accidental injury to residents with a cognitive impairment. The hairdresser room, containing hair dryers and other heated hair equipment, was unsecured. Staff informed inspectors that sluice rooms and stores should be locked, however many were unsecured and the keys for many rooms were hanging on the door frames, or left in the key holes in the door and this practice had not been risk assessed. A kitchen located beside an activities room was open and contained a hot water boiler and cooker posing a potential risk of injury to residents with a cognitive impairment. In addition, a radiator on a corridor which was turned on during the day of the inspection was scalding in temperature and posed a burns risk to residents. This was brought to the immediate attention of staff. On this inspection the inspector saw that locks have been placed in all storage/sluice rooms and cupboards and rooms checked by the inspector were found to be secured. The radiator was fitted with a thermostatic control valve and was cooler. A radiator cover was ordered but required to be custom made which resulted in a delay in arrival.

On the previous inspection the inspectors found that the centre had inadequate infection prevention and control measures in place in relation to hygiene in the centre. Inspectors observed that staff did not engage in hand hygiene at all appropriate stages when caring for residents and working in the centre. Some of the hand sanitising gel dispensers in the centre were empty. Laundry trolleys were stored in sluice rooms posing a risk of cross contamination. Blue aprons which were worn by staff when serving meals were stored on the air dry racks for containers in the sluice rooms. A shower chair and commode chairs were inappropriately stored in sluice rooms. On this inspection the person in charge and training records confirmed that Infection control training was provided to staff on various dates which commenced in September. Hand hygiene audits and training also commenced in September 2015 and were ongoing. The inspector observed staff using personal protective equipment such as gloves and aprons and staff were observed using the hand sanitiser gel dispensers provided throughout the centre. The person in charge told the inspector that daily checks are made to ensure hand hygiene sanitizers are filled and functioning. The hand sanitiser gel dispensers units sampled by the inspector contained an appropriate amount of gel. The person in charge told the inspector that the process for room cleaning has been revised with all housekeeping staff and colour coded mops and dusters were in place for cleaning. The inspector saw that this was in place and staff demonstrated their knowledge of the correct mops and cleaning cloths for different areas of the centre. There were two cleaning staff on duty and two laundry staff on duty on the day of the inspection and the centre and the laundry were found to be clean. The inspector saw that the sluice rooms were free from inappropriate items and the new sluice room in the new build will replace one of the older sluice rooms that did not have a stainless steel sluice sink for
discarding waste. Overall the inspector saw there had been a number of improvement but reinforced to the person in charge and staff the requirement to remain vigilant and abide by best practice infection control guideline to prevent cross contamination.

**Judgment:**
Compliant

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**Outcome 09: Medication Management**

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

**Theme:**
Safe care and support

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

**Findings:**
On the previous inspection the inspectors identified a number of issues requiring action in relation to medication management in the centre and were identified as major non compliance in this area.

Storage of medications was found to be inadequate and a number of unlabelled medications and creams and out of date medications were found in the drug trolley.

The system for recording the administration of medications on the medication administration record (MAR) was not adequate or in accordance with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management, as required by Schedule 3(4)(d).

There was an over-reliance on faxed prescriptions in the centre which remained in use long past the accepted time frame and there were often contradicting directions between faxed and regular prescriptions which increased the risk of medication error and had resulted in at least one medication error which was found on the day of inspection.

The medical review of residents' medication every 3 months was inconsistently documented on residents' prescriptions with periods of up to 5 months seen between the review dates documented on one prescription. The inspectors discussed the seriousness of this situation with nursing staff and the person participating in management and highlighted that centre’s practice around the use of faxed prescriptions was not in accordance with An Bord Altranais agus Cnáimhseachais na hÉireann Guidance to Nurses and Midwives on Medication Management 2007.

On this inspection the inspector accompanied a staff nurse on a medication round. The practice of checking, dispensing, and recording of the drugs administered was in line with current legislation. Photographic identification for residents was present. A copy of
An Bord Altranais medication guidelines was readily available. The medication trolleys were secured and the medication keys were held by the nurse in charge. Controlled drugs were maintained as per professional guidelines and a sample checked by the inspector corresponded fully with the medication count completed at the commencement of each shift. Medication management was the subject of an audit by the provider and by the pharmacist and the inspector saw the results of these audits. Since the last inspection the medication management system in the centre had been totally revised with the assistance of the pharmacist. Adequate storage and disposal of medications had been corrected and the inspector saw that out of date and discontinued medications were removed from the trolley and put into a special box which is locked in the cupboard to go back to the pharmacy for safe disposal of same. New medication fridges were installed and a daily rolling control drugs register was implemented. The person in charge and all nursing staff spoken to confirmed that faxed prescriptions are only used in emergency situations and then will be strictly used for 72 hours only and then GP must write up medications following that. The centre had introduced a system to ensure three monthly reviews of medications were undertaken by the GP by notifying the GP in advance and documentation of same. A new drug administration recording sheet had been implemented due to the issues identified on the previous inspections of how nurses were documenting medications administered. This administration sheet contained all details on the medications to be administered including photographic identification. The times of administration matched with the prescription sheet and there was space to record comments on withheld or refused medications. The nurses reported that they felt this was a far safer tool to use for recording administration of medications and overall expressed great satisfaction with all the changes implemented which they felt decreased the risk of medication errors in the centre. The inspector saw that all nursing staff had undergone medication training during 2014 and 2015 and nurses told the inspector the pharmacist provided medication training to them on a variety of medications the last training session was on laxative usage.

As discussed under outcome 11 health and social care the inspector found that one residents care plan did not guide the practice around the administration of pain relief and PRN pain relief for one resident and there was inconsistent administration of PRN medication with little evidence documented of which medication was most effective for the resident to ensure pain relief.

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:
On the previous inspection the inspectors viewed a sample of residents’ care plans, medical and nursing notes. Residents had a comprehensive assessment of their health and social care needs conducted on admission to the centre. There was evidence of visits from general practitioners and allied health care professionals (dieticians and speech and language therapists). Assessments of residents’ activities of daily living were updated every four months. Care plans were in place to guide the health and social care needs of residents. However, the care plans were generic in format and content and did not identify individual needs and choices. As the care plans had pre-printed interventions recorded, inspectors could not be assured of the contribution of care plans to guiding resident care or improving their individual quality of life. On this inspection the inspector found the situation remained unchanged and care plans were in place which had not been personalised to the residents and were not updated when the residents needs changed. The inspector viewed the care plan for one resident who was suffering from pain and was on a complex regime of pain medications. The care plan stated she was on a pain relieving patch which the nurse confirmed had been discontinued a long time ago but the care plan was not updated. This could lead to errors, the plan of care did not reflect the care given to the resident nor did it direct care and in fact there was no evidence of a proper plan as to which of the as required medications to give to the resident which suited her best and provide continuity of care.

The inspector saw that the daily progress notes were kept in a separate folder from the care plans. The nurses said they really only looked at the care plans on the requirement to evaluate same on a four monthly basis. Therefore looking at all of the above the inspector formed an opinion that the care plans were not a live document used to direct care, they were not personalised and staff were not always familiar with their content. This was discussed in detail with the person in charge and nursing team and they acknowledged the requirement to ensure the care plans were live documents directing care for all residents.

Judgment:
Non Compliant - Major

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

**Findings:**
On the previous inspection the inspectors found that the centre was homely and well decorated throughout. There were 46 single bedrooms and 7 twin bedrooms which had en-suite bathrooms. However, there was a six-bed bedroom which was unsuitable to protect the privacy and dignity of the residents. This had an impact on residents as they were unable to undertake personal activities in private or to meet with visitors in their bedroom in a private area. This had also been a finding and action on the last inspection. Inspectors noted that building works were well advanced in relation to providing alternative bedroom accommodation to this six-bed bedroom.

On this inspection the provider had applied for a variation to their conditions of registration and had applied to register nine new bedrooms which were to replace the current six bedded room and three twin rooms were to be converted to single rooms. The new rooms were in a purpose built wing which contained nine large single en-suite rooms, a sluice room, storage rooms and a nurses station. The inspector saw that the new rooms were very large with plenty of storage space including locked storage space, they also contained a seating area for table and chairs. They were completed to a high specification with large en-suite bathrooms. There were two call bells in each room one by the bed and one for the seating area. The current six bedded room is to be converted into an activities room. The overall number of residents in the centre were to remain the same. The new sluice room was extra large and contained all the required equipment this will replace the slice room that was identified on the previous inspection not having a suitable sluicing sink in place.

The inspector identified the lack of a communal space in the new unit or in the proximity of the new unit with the main sitting and dining room being a long walk for residents. The person in charge informed the inspector of the plans to put a seating area outside of the new unit where the old nurses station currently is as this will be replace with the new nurses station.

Overall the inspector found the premises and residents bedrooms to be of a high standard and much personalised throughout.

**Judgment:**
Compliant

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

**Findings:**
The centre had a complaints procedure that was adequately displayed for residents and visitors attention in the main reception. There was evidence that all complaints were recorded in the complaints log with details of the complaint, the investigations and the solutions recorded. However, on the previous inspection the inspectors found that it was not always recorded whether or not the complainant was satisfied, as required by Regulation 34(1)(f). Also, it was not clear from the complaints log whether measures required for improvement were implemented as a result of complaints. On this inspection the centre had introduced a new system for logging of complaints which recorded whether or not the complainant was satisfied, as required by Regulation 34(1)(f). The inspector also saw evidence that actions were taken as a result of complaints leading to improvements in service this was evidenced by improvements in the service at breakfast time and these were discussed with staff. Complaints were also seen to be the subject of audit and improvements resulting from same.

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

**Findings:**
On the previous inspection the inspectors found that many toilets and shower rooms doors did not have door locks on the inside to facilitate resident privacy. On this inspection the inspector saw that locks had been put in place on bathroom and shower doors which protected the privacy and dignity of the residents.

On the previous inspection CCTV cameras were in place at the front and rear entrance to the centre as well as four CCTV cameras on bedroom corridors. There was inadequate signage in place to notify residents and visitors that internal CCTV was
recording in the centre. On this inspection CCTV cameras were only in place at the entrances to the centre and externally. Signage was in place to notify residents and visitors of same. The centre had a policy on the use of CCTV which outlined that the CCTV cameras were recording as a security measure.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 18: Suitable Staffing</strong></th>
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<tr>
<td><strong>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.</strong></td>
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**Theme:**
Workforce

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

**Findings:**
On the previous inspection staff training records viewed by inspectors showed that not all staff had up to date training in manual handling, behaviours that challenge and fire safety. The last elder abuse training in the centre was out of date as it was last held in 2012. On this inspection the inspector saw that there had been a big investment in training since the last inspection and as discussed in previous outcomes mandatory training was up to date for staff. Training records and staff confirmed that training in manual handling, behaviours that challenge fire safety and elder abuse training had taken place over the last six months. Other training such as medication management had also taken place.

There was an actual and planned staff roster in place and on the day of inspection staff numbers were on duty as outlined on the roster. The inspector was satisfied that there was twenty-four nurse on duty in the centre to meet the needs of the residents. Nurses’ registration numbers with An Bord Altranais agus Cnáimhseachais na hÉireann were up to date and many healthcare attendants had FETAC level 5 training. Staff performance appraisals were conducted annually by the person in charge and these were seen in the staff files. Residents and relatives spoken to were very complimentary about the staff and the care that they gave to residents and this corresponded with the findings from the resident and relatives surveys.

The person in charge informed the inspector that they had recruited a new nurse who was due to commence in the next number of weeks but generally there was little staff turnover.
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:

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**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:**
There was no annual review of the quality and safety of care and the quality of life of residents in the centre as required by Regulation 23.

1. **Action Required:**
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

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

Please state the actions you have taken or are planning to take:
Will amalgamate all data collected over 2015 into Annual Review: Contents of the review will address: Admissions, Discharges, Deaths and Transfers, Feedback from Resident and Family Satisfaction Surveys, Feedback from Food Survey, Feedback from Resident Council Meetings, Complaints, General Staff Training for the year including Fire Training and Fire Drills, Safety Reviews, General Facility Improvements that were carried out, Reports of Quality Management Reviews on Care Plans, Wound Care, Catheter Care, Continence Care, Unplanned Weight Loss, Falls and other Incidents. It will also include Plans for 2016; Staff Training, Facility Improvement Plans, any Additional Services that will be implemented and Quality Management Audits planned for 2016

Proposed Timescale: 31/01/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector saw that the centre was accepting consent for the use of bed rails from family members for the use of restraint, this practice required review as legally consent cannot be given for an adult. Best practice guidelines state it should be discussed with family but the resident themselves is the only person who can consent.

2. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
HSE Policy on Use of Physical Restraints in Designated Care Units for Older People (2010) has been reviewed with staff. In addition The Draft Document on National Consent Policy by HSE Quality and Patient Safety Directorate has been reviewed and relevant areas discussed at staff meetings.

The use of bed rails been reviewed and the actual consent form changed. Consent is obtained only from residents themselves.
The nurse who performed assessment signs off the consent form with the resident. If a resident cannot write but is fully cognitive the resident may place an X mark on consent form and this can be witnessed by nurse.
If the resident lacks capacity to consent, the nurse will determine based on assessment what is in the resident’s best interest decided by reference to their values and preferences if known. Consent will not be sought from family members but discussion
and feedback will take place with family members and this information will be documented in resident’s file.

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

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

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents care plans were found not to be person centred to the residents and did not direct the care for the residents

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

**Please state the actions you have taken or are planning to take:**
We plan to totally revise our care plans. Our revised care plans will be person centred that reflect the values, preferences and choices for each resident and will be used to direct the care given to residents on a daily basis.

**Proposed Timescale:** 30/03/2016

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Although the care plans were generally reviewed on a four monthly basis they were not revised and updated to the changing needs of the residents.

**4. Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**
Nurses will revise their current care plans and will continue to revise every four months or more often based on changes in resident’s needs in consultation with the resident and where appropriate the resident’s family.
Monthly audits will continue and will target 10 care plans per month. The audit will include checking that the care plans are updated and reflect the actual changing needs
of each resident

**Proposed Timescale:** 28/02/2016