<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Waterford Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000255</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Ballinakill Downs, Dunmore Road, Waterford.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>051 820 233</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:waterfordnursinghome@mowlamhealthcare.com">waterfordnursinghome@mowlamhealthcare.com</a></td>
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<tr>
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<tr>
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<td>Mowlam Healthcare Services</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Pat Shanahan</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila Doyle</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary O'Donnell</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 to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 29 February 2016 10:30
To: 29 February 2016 17:30

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>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 06: Absence of the Person in charge</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</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Management</td>
<td></td>
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<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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</tr>
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Summary of findings from this inspection
This follow up inspection was carried out in response to areas of significant risk identified during previous inspections.

Overall inspectors found that satisfactory progress was being made to implement and sustain improvements aimed at improving outcomes for residents. The provider and person in charge demonstrated a very clear commitment to addressing all areas of concern in a timely way and cooperated thoroughly with the inspection and regulatory process.

There was evidence of increasing levels of 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. Improved practice was noted in relation to meeting the health and social care needs of residents. However, care plan documentation required additional improvement.
Risk management procedures had improved and the risk management policy was being implemented. However, inspectors found that additional improvement was required around fire safety procedures and the use of restraint. The action in relation to institutional practices had been addressed as had incident reporting.

Improvements were required to the management of nutrition and complaints. Systems for the reviewing and improving the quality and safety of care also required improvement to ensure the annual review was available to residents.

These matters are discussed further in the report and in the Action Plan at the end of the report.
Outcome 02: Governance and Management

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

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors were satisfied that improvements had occurred regarding the adequacy of governance and management systems in the centre although some improvement was required to ensure compliance with the Regulations.

Improvements continued regarding the monitoring and development of the quality and safety of care delivered to residents. The annual review of the quality and safety of care delivered to residents had been completed in March 2015. Inspectors saw that this was comprehensive. However a copy of the review was not made available to residents as required by the Regulations. Staff said that the current version which was completed using a computerised system, contained confidential information and that this issue had been addressed and plans in place to ensure that the next report due in March 2016 was suitable for sharing.

Audits were being completed on several areas such as care planning documentation, medication management and the use of restraint. An audit schedule was in place for the coming year. Inspectors saw that the results of these were analysed and shared with staff. Action plans were in place to address the improvements required. Resident satisfaction surveys had also been completed.

There was a clearly defined management structure that identified the lines of authority and accountability. Inspectors met the person in charge and the assistant director of nursing and both were clear on their roles and responsibilities. Both discussed the quality improvement plan in place to ensure compliance with the Regulations and Standards. Inspectors saw that this was specific with actions and timescales outlined and addressed areas identified for improvement at previous inspections.
Judgment:
Non Compliant - Moderate

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
This outcome was reviewed briefly at this monitoring event.

The person in charge worked in a full-time capacity and held the necessary qualifications and experience for this post. He outlined his plans for his continuous professional development including undertaking additional training on clinical issues such as wound care and human resource issues such as mediation.

Inspectors met with the person in charge and the operations manager who outlined the work being undertaken to bring about the necessary improvements to the service. Both outlined their commitment and the commitment of the provider to this process.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The provider was aware of the regulatory requirement to notify the Authority should the person in charge be absent for more than 28 days. To date this had not been necessary.
The newly appointed assistant director of nursing deputises for the person in charge in his absence. Inspectors interviewed this person and found that he was aware of his responsibilities and had up to date knowledge of the Regulations and Standards. He was actively involved in the management of the centre and demonstrated a clear commitment to continuous improvement in quality person-centred care through regular audits of all aspects of resident care. Together with the management team he had plans in place to work through the actions required from the previous inspections.

**Judgment:**  
Compliant

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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

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

**Findings:**  
Inspectors found that the provider had taken steps to address the failings from the previous inspection. However, additional work was required around the use of restraint.

Bedrails were the only reported form of restraint in quarterly notifications submitted to the Authority. At the time of inspection, 50% of the residents had bed rails in use. Inspectors saw that some alternative devices were in use but their use was not consistently in line with the policy. For example a resident who had a low-low bed and a crash mat also had bedrails in place. In addition there was limited documented evidence that alternatives had been trialled before bed rails were used.

Risk assessments were carried out and bumpers were in use to mitigate the risk of injury from a bedrail. Care plans were implemented to supervise residents using bedrails and two hourly checks were recorded. The assistant director of nursing told inspectors of concerted efforts being made to promote a restraint free environment. He had identified eight residents who were currently using bed rails and were suitable for alternative devices such as low-low beds or grab rails. These measures would achieve the goals of care without restricting the residents’ freedom.

Actions required from the previous inspection to address institutional practices had been completed. Inspectors found that night staff no longer routinely assisted residents to get up and dressed before day staff came on duty. Household staff confirmed that they began work at 8am and did not use any machines which might disturb sleeping...
Residents confirmed that this was the case.

The safeguarding policy was revised in Feb 2016 and now referenced the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2014). It guided the overall processes and procedures to be followed. Training records available indicated that all staff had completed training on the prevention, detection and response to abuse. Staff who spoke with inspectors confirmed that they had attended training and were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. An allegations of abuse notified to the Authority had been managed in line with the policy and inspectors saw that the safety of residents was prioritised throughout the process.

The policy for the management of behaviours that challenge had been reviewed in January 2016. It was a comprehensive policy that included assessment protocols, assessment guidelines and interventions to support a person centred approach to working with people who had behaviours that challenge.

Records showed that training specific to behaviours that challenge had been completed by staff. Assessments had been completed to out rule underlying causes such as pain or boredom and to identify triggers which were likely to precede the behaviour. Care plans were in place to support a consistent approach to care and measures put in place to monitor that the care plans were implemented. Two residents had enhanced supervision arrangements and location charts were updated accordingly.

Inspectors discussed with providers the fact that the communal environment had not been considered in relation to its possible impact on residents. The high noise levels in the communal room on the first floor and bells ringing on both floors had not been considered as antecedents and sensitivities which may not support positive behaviours. Inspectors noted that a lot of residents chose to stay in their rooms rather than using the communal day room upstairs.

Each resident had access to a secure locked facility in their bedroom. There was an up to date policy on the security of residents' accounts and personal property. The provider was an agent for four residents and there were robust systems in place to safeguard residents’ monies. All transactions were appropriately documented with lodgements and withdrawals documented and receipts for petty cash transactions. The petty cash amounts and records checked all correlated. Inspectors discussed with the services manager ways to improve the process by increased involvement of the resident if possible and if not two staff members signing for petty cash transactions.

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:**
Inspectors found that the provider had taken steps to address the actions required from the previous inspection. However, the provider had failed to take adequate precautions against the risk of fire.

A recent audit found that there was a shortage of ski sheets to support the evacuation of immobile residents in an emergency. However there was no evidence that these were being sourced.

Inspectors also noted that a fire door was inappropriately held in an open position by a chair and therefore would not close as intended in the event of the fire alarm.

Fire drills were completed on a regular basis. However the records were found to be inadequate. Records of the most recent fire drill in January 2016 did not include the names of staff in attendance or evidence of learning.

Fire evacuation instructions were clearly displayed within the centre and all fire exits were unobstructed. There was an emergency plan in place detailing procedures to be followed in the event of fire, flood, power outage and loss of water or heat.

Staff spoken with were knowledgeable regarding fire safety and evacuation procedures, and had completed fire safety training. The records showed that there was regular servicing of the fire detection and alarm system and the fire equipment. The wiring and the emergency lighting system had recently been upgraded. A documented system of in-house checks relating to fire safety was also in place.

Inspectors saw that comprehensive risk assessments were undertaken by staff and care plans put in place to mitigate clinical risks. Actions required from the previous inspection had been completed.

There were policies and procedures in place for risk management, emergency planning and health and safety within the centre.

Inspectors reviewed the health and safety statement that was on display within the centre and also reviewed completed risk assessments. Incidents including falls were recorded electronically. There were procedures in place for the reporting and management of incidents, which included an analysis of all incidents.
Staff had completed manual handling training. Moving and handling risk assessment forms contained details of the appropriate sized sling for use when hoisting residents. Inspectors saw evidence of good manual handling practices.

Staff had completed hand hygiene training and an infection control audit of hand hygiene practice had been recently completed. Alcohol gels and hand washing facilities were appropriate to support good practice. Personal protective equipment was available to staff and clinical waste was appropriately managed and securely stored.

The risk management policy was reviewed by inspectors and included measures and actions to control the risks of self harm, slips trips and falls, unexplained absence of a resident, aggressive behaviour and resident abuse. There was a risk register in place detailing a description of identified risks, persons deemed to be at risk and control measures in place to mitigate the identified risk. There were plans to implement drills to improve the response in the event that a resident goes missing.

**Judgment:**
Non Compliant - Moderate

### Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

**Theme:**
Safe care and support

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

**Findings:**
A record of all incidents occurring in the designated centre was maintained. All incidents requiring notification had been submitted to the Authority within the appropriate timelines. The action required from the previous inspection relating to delayed notifications had been addressed.

Quarterly reports which held the required information were submitted to the Authority within the required timescales.

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

Findings:
Inspectors were satisfied that each resident’s wellbeing and welfare was maintained by appropriate evidence-based nursing, medical and allied health care. However the arrangements to meet each resident's assessed needs were not consistently set out in an individual care plan.

Following review of a sample of care plans inspectors identified some gaps in the documentation. Inspectors noted that a resident had epilepsy; however there was no care plan in place to guide staff around the management of this issue. In addition inspectors noted that in some cases the care plans had not been updated to reflect the recommendations of various members of the multidisciplinary team. For example inspectors saw that a resident had been referred to a speech and language therapist (SALT). Specific recommendations were made regarding providing assistance at meals. However the care plan had not been updated to reflect this.

Inspectors also noted that in the sample of care plans reviewed there was no documented evidence that residents or relatives were involved in the development or review. This was discussed with the assistant director of nursing who had already identified this at a recent audit.

Otherwise inspectors were satisfied that each resident’s wellbeing and welfare was maintained. There was evidence of pre-admission assessments in residents’ records and residents had full comprehensive assessments completed on admission which included dependency level, moving and handling needs, falls risk assessment, pressure sore risk assessment, nutrition and mental test score examination. These assessments were generally repeated on a four monthly basis or sooner if the residents’ condition required it.

Inspectors reviewed the procedure for wound management and found that assessment and treatment plans were in place. Appropriate documentation was available for use. This was identified as an area for improvement the last inspection. Additional advice and support was available from tissue viability nurses if required. The procedures in place relating to other clinical conditions such as falls management and diabetes care were also reviewed and found to be in line with best practice. Weight management is
discussed in more detail under Outcome 15.

Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available on referral or privately including speech and language therapy (SALT) and dietetic services. Physiotherapy services were available in the centre on a weekly basis. Occupational therapy services were available through the parent company. Chiropody, dental and optical services were also provided. Inspectors reviewed residents’ records and found that some residents had been referred to these services and results of appointments were written up in the residents’ notes.

Residents were seen enjoying various activities during the inspection. Each resident’s preferences were assessed and this information was used to plan the activity programme. The person in charge and operations manager discussed plans to improve this further including recruitment of additional staff.

Judgment:
Non Compliant - Moderate

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

Theme:
Person-centred care and support

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

Findings:
The complaints policy was displayed in the reception area and was included in the residents' guide and statement of purpose. Inspectors noted that the policy at reception was difficult to read because the font was quite small.

Inspectors followed up on a complaint raised by a resident relating to lack of access to TV channels. The person in charge told inspectors that he had dealt with this matter and thought it had been resolved. Inspectors found that the issue had not been documented as a complaint and concluded that all avenues had not been explored to resolve the complaint to the satisfaction of the resident. They also held the view that systems were needed to ensure that service improvements which resulted from complaints are sustained.

Complaints were an agenda item at the quarterly governance meetings. There was a nominated person to ensure that all complaints were appropriately responded to and that the complaints officer maintained records in line with regulatory requirements.
Judgment:
Non Compliant - Moderate

**Outcome 15: Food and Nutrition**

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

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

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

**Findings:**
Inspectors were not satisfied that the nutritional needs of all residents were met.

There were two dining rooms available to residents, one on each floor. Inspectors visited both dining rooms at lunch and tea time. In the downstairs dining room, inspectors heard residents being offered a choice from the menu on display. Tables were laid and meals were nicely presented. It was noted that meals were an unhurried social experience, with appropriate numbers of staff available to support residents if required.

However this was not the case upstairs where many dependant residents lived. Tables were very sparsely laid at lunch time and not laid at all for some residents at tea time. Inspectors did not hear any resident being asked what they would like. Staff told inspectors that they already knew the residents' preferences. Some staff spoken with did not know if any alternative choice was available for residents who required modified consistency diets.

Drinks were served in flimsy plastic cups which made it very difficult for residents to manage independently. This was pointed out to the assistant director of nursing and glasses were provided. Similarly there was no obvious choice of drink available to the residents.

Inspectors noted that some residents upstairs got a milk pudding at 4pm. Staff spoken with said that these residents would get something later that evening but inspectors were not satisfied that this was sufficiently wholesome and nutritious and was certainly not served at conventional meal times. In addition it did not appear as if any choice was available.

Inspectors were also concerned that the recommendations of the speech and language therapist for a resident were not being followed. Inspectors saw a resident sitting in an unsuitable and unsafe position while being assisted to eat. This was immediately brought to the attention of staff and addressed. Inspectors sought assurances that all
staff would be made aware and follow specialist advice when supporting residents to eat or drink.

Inspectors discussed these issues with the person in charge and provider at the end of inspection. Agreement was reached that this would be addressed immediately.

Otherwise inspectors saw that validated assessment tools were used to identify residents at potential risk of malnutrition on admission and were regularly reviewed thereafter. Weights were routinely recorded on a monthly basis or more frequently if required. Inspectors saw that records of residents’ food intake and fluid balance were accurately completed when required. Records showed that some residents had been referred for dietetic review. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

Inspectors visited the kitchen and found that it was maintained in a clean and hygienic condition with ample supplies of fresh and frozen food. A documented system was in place to communicate residents’ dietary requirements and preferences to catering staff. Inspectors found that the chef was very aware of and knowledgeable about all residents’ preferences, likes and dislikes as well as those requiring modified diets. The chef was also aware of those residents who were at risk of poor nutrition and that arrangements were in place to address this. Inspectors found that contrary to what was happening in practice on the first floor, adequate choices were in fact available for residents.

**Judgment:**
Non Compliant - Moderate

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**Outcome 18: Suitable Staffing**

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

**Theme:**
Workforce

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

**Findings:**
Inspectors were satisfied that there were appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services and that all staff were supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.
Inspectors examined a sample of staff files and found that all were complete. Up to date registration numbers were in place for nursing staff. Inspectors reviewed the roster which reflected the staff on duty.

The person in charge and operations manager discussed ongoing recruitment measures and confirmed that additional staff were ready to commence employment in the centre.

The provider and person in charge promoted professional development for staff and were committed to providing ongoing training to staff. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. Additional training was also planned for the coming months including training on infection control, medication management, end of life care and wound care.

Inspectors also saw where staff appraisals were undertaken on a yearly basis and the results of these were used to plan a training programme. Individual action plans were in place should a staff member require additional support or supervision.

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:

Sheila Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider's response to inspection report

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<td>OSV-0000255</td>
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<tr>
<td>Date of inspection:</td>
<td>29/02/2016</td>
</tr>
<tr>
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<td>15/03/2016</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the annual review of the quality and safety of care was not made available to residents

1. Action Required:
Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The annual review of the quality and safety of care will be presented to staff at the Annual Quality and Governance meeting on 24th March; and also to residents/relatives during the scheduled Residents/Relatives meeting on 13th April.

Proposed Timescale: 13/04/2016

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:
There was limited documented evidence that alternatives had been trialled before bed rails were used.

Bedrails and alternatives were in use for some residents.

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:
A full review of bedrail use in the home has commenced. All residents currently using bedrails are being reassessed to identify alternative options in accordance with national policy. Alternatives to bedrails are considered and if bedrails are indicated/required, there is documentary evidence that they are used as a measure of last resort.

Proposed Timescale: 06/04/2016

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a shortage of ski sheets to support the evacuation of immobile residents in an emergency.

3. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.
Please state the actions you have taken or are planning to take:
Ski sheets have been provided for all immobile residents to support safe evacuation of residents in an emergency situation

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<tbody>
<tr>
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<tr>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A fire door was inappropriately held in an open position by a chair.

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

Please state the actions you have taken or are planning to take:
All doors are unobstructed and are not propped open. Doors will be kept closed. If any door is required to be kept open, a risk assessment will be undertaken and a magnetic door guard will be fitted where indicated or required. The door guards will close automatically when the fire alarm sounds to ensure the doors are closed as intended in the event of a fire.

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<tbody>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inadequate records of fire drills were maintained.

5. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Records of recent fire drills have been reviewed and updated to include the names of all attendees, an evaluation of the drill and details of learning outcomes, in line with regulation 28.
**Outcome 11: Health and Social Care Needs**

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

Care plans were not consistently updated to reflect the recommendations of various members of the multidisciplinary team.

**6. Action Required:**

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

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

All residents' assessments and care plans are currently under review to ensure multidisciplinary person centred care is provided for all residents, and that the documentation clearly reflects the advice and recommendations of the multidisciplinary team.

**Proposed Timescale:** 29/04/2016

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

There was no documented evidence that residents or relatives were involved in the development or review of the care plans.

**7. 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:

The PIC and ADON have commenced meeting with all residents'/relatives’ to ensure resident and family input when developing/reviewing the plan of care for each resident. The input of residents and/or family will be confirmed in the Resident/Family Communication section of the electronic care plan.

**Proposed Timescale:** 29/04/2016
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**Outcome 13: Complaints procedures**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all complaints were logged.

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

**Please state the actions you have taken or are planning to take:**
All complaints/concerns will be documented in the electronic resident record (complaints log) in line with company complaints policy. All complaints will be reported, recorded, investigated and a responded to. All actions and outcomes will be clearly documented, including any service improvements and the satisfaction of the complainant, in line with best practice.

**Proposed Timescale:** 01/04/2016

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence that the required service improvements were put in place following a complaint.

**9. Action Required:**
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

**Please state the actions you have taken or are planning to take:**
All complaints will be documented and investigated and a response provided to the complainant in line with the complaints procedure. Service improvements will be put in place if appropriate and this will be documented as an action and learning outcome in the electronic complaints record. All complaints and service improvements implemented following complaints will be reviewed and presented as part of the review of quality and governance.

**Proposed Timescale:** 24/03/2016
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**Outcome 15: Food and Nutrition**

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Choice was not offered to residents on a modified consistency diet.

**10. Action Required:**
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

**Please state the actions you have taken or are planning to take:**
The practice of ensuring that all residents are always offered a choice at mealtimes, including modified consistency diets, has been reviewed and improved. The practice has now been fully implemented to ensure that all staff offer and document all residents’ choices from the daily menu, and that they inform and update the catering staff. Compliance with these arrangements in all dining areas in the home will be monitored by the PIC and CNM.

**Proposed Timescale:** 20/03/2016

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some residents appeared to have their evening meal at 4pm.

**11. Action Required:**
Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

**Please state the actions you have taken or are planning to take:**
The dining experience has been reviewed to ensure that all residents’ meals are served at reasonable times, taking the individual residents needs and preferences into consideration. Evening snacks are routinely offered to all residents and a selection of hot or cold drinks and snacks are available to residents at any time.

**Proposed Timescale:** 31/03/2016
Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Specific recommendations regarding assistance and techniques were not followed when assisting a resident with their meal.

12. Action Required:
Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

Please state the actions you have taken or are planning to take:
The dining experience has been reviewed to ensure that all residents’ choices and nutritional needs are appropriately provided for. Staff are aware of the specific dietary recommendations and requirements of all residents. The PIC and CNM will monitor compliance with this practice to ensure that the specific recommendations are followed when assisting residents and that the positive dining experience in the main dining room is reflected in all dining areas in the home.

Proposed Timescale: 31/03/2016