**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>Cahermoyle House Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000412</td>
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<tr>
<td>Centre address:</td>
<td>Cahermoyle House, Ardagh, Newcastlewest, Limerick.</td>
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<tr>
<td>Telephone number:</td>
<td>069 76 105</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:wbeaton@cahermoylehouse.com">wbeaton@cahermoylehouse.com</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Candor Holdings Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Martin Lynch</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Caroline Connelly</td>
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<tr>
<td>Support inspector(s):</td>
<td>Mary Costelloe and Michelle O' Connor Day 1</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<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>9</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 announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: To:
23 February 2016 10:30 23 February 2016 18:30
24 February 2016 09:00 24 February 2016 17:00

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

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<th>Outcome</th>
<th>Our Judgment</th>
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<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
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<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 06: Absence of the Person in charge</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Compliant</td>
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<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

This report sets out the findings of an inspection of Cahermoyle House Nursing Home, which was announced six days prior to the inspection. This was a follow-up inspection that was carried out to monitor the compliance with the regulations due to the high level of non-compliance identified during previous inspections in July, September and October 2015.

The provider had completed an application to renew the registration of the centre but due to the high levels of ongoing non-compliances the authority had issued a notice of proposal to refuse the application for registration renewal. The provider, in its written representation to the Authority, identified that in its current make-up, the Board of Candor Holdings Limited did not have the cumulative skills, knowledge and
abilities that a Registered Provider needs to possess in order to be considered to be fit to be a Registered Provider. The written representation also outlined the provider's plans to address this issue and to co-op to the board personnel with the required expertise to undertake the role of provider nominee and subsequent notifications of these changes were received by the authority. During this inspection the inspectors inspected against the representation received and followed up on the actions from the previous inspection. This inspection will also serve to inform a decision in relation to the application by the provider to renew the registration of the centre.

Since the last inspection there had been a number of changes to the management team including the provider nominee. The board had employed the services of a consultancy firm who had for a short period of time been co-opted onto the board and undertook the role of provider nominee. Just prior to this inspection the inspectors were informed that although the consultancy services were to continue to the centre one day per week the personnel were no longer part of the board and therefore no longer acting in the role of provider nominee. The person in charge who had been newly appointed on the previous inspection had also resigned his post and had left the centre.

The assistant director of nursing (ADON) was acting as the person in charge at the time of the inspection and for the three weeks prior to the inspection. He told the inspectors that he was receiving significant support and guidance from the management consultants which gave him confidence to take on the role in a full time basis.

The provider and person in charge had suspended all admissions to the centre despite having nine empty beds to ensure a safe service was provided to residents until they could recruit further nursing staff and increase their compliance with the regulations.

During the inspection the inspectors met with residents, the acting person in charge, the provider nominee and members of the staff team. Inspectors observed practices, the physical environment and reviewed documentation such as policies, procedures, risk assessments, reports, residents' files and training records. Inspectors found improvements in a number of key areas since the previous inspection, including the premises, activities and provision of equipment which had a demonstrable effect on improving residents’ quality of life. Staff were observed on this, as on previous inspections, to support residents in a dignified and warm manner.

Failings identified to be at the level of major non-compliance at the previous inspection relating to premises, health and safety, safeguarding and governance were no longer at the level of major non-compliance at this inspection. Significant progress was seen in addressing actions from the previous inspection. On the previous inspections undertaken in September and the triggered inspection undertaken in October 2015 there were a total of 30 actions, on this inspection this has reduced to eight actions required. Of the 13 outcomes inspected against and followed up on this inspection, five were found to be compliant, 1 substantially compliant, and in the remaining 7 outcomes moderate non-compliance was
identified.

Further improvement was required in governance, care planning, medication management, premises, documentation, safeguarding, staffing levels and the absence of the person in charge, governance. These areas are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report.
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:
Since the last inspection there had been a number of changes to the management team including the provider nominee. The board had employed the services of a consultancy firm who had for a short period of time been co-opted onto the board and undertook the role of provider nominee. Just prior to this inspection the inspectors were informed that although the consultancy services were to continue one day per week they were no longer part of the board and therefore no longer acting as provider nominee. The person in charge who had been newly appointed on the last inspection had resigned his post and had left the centre.

The assistant director of nursing (ADoN), who had significant experience in supporting residents needs, was acting as the person in charge at the time of the inspection and for the three weeks prior to the inspection. He told the inspectors that he was receiving significant support and guidance from the management consultants which gave him confidence to take on the role. There was evidence that the person in charge was engaged in the governance, operational management and administration of the centre on a day-to-day basis.

The inspectors met with the provider who demonstrated a wiliness to engage with the authority to address the areas of non-compliance identified. He informed them that he was actively recruiting a new person in charge and a person to take on the role of the provider nominee and was confident of an appointment in the next number of weeks. He informed the inspectors that he had employed the services of the management consultants since the 04 November 2015 to provide the centre with advice and guidance to ensure delivery of effective governance and management to ensure effective compliance with the regulations and the standards. He stated he had made financial resources available to ensure the management team can effectively manage the centre.
and address the environmental non-compliances identified on previous inspections. The inspectors saw that all of the actions required had been addressed and completed or were being in the process of being addressed.

The provider has suspended all admissions to the centre despite the centre having a large number of vacancies due to lack of nursing staff and to allow the service address and correct the non-compliances.

A very comprehensive annual review of the quality and safety of care and support in the designated centre was undertaken by the management consultants in accordance with the standards. This review was made available to the inspectors and there were a number of recommendations and actions from this review that are currently being actioned.

The provider under the guidance of the management team had invested heavily in training for staff particularly in key mandatory areas such as protection, moving and handling, managing responsive behaviours. They facilitated the costs of the services of a external trainer/facilitator who was on site working with staff two to three days per week. She provided training, guidance/practice development on all aspects of care from moving and handling, pressure area care, hygiene practices, infection control and focused on developing the skills of staff in providing care to the diverse client group of residents. The staff that spoke to the inspectors all highlighted how beneficial this has been for all staff and residents and staff reported feeling valued and invested in.

The person in charge demonstrated progress had been made in a number of areas under his control. A new quality management system had been implemented under the guidance of the management consultants and the person in charge was now maintaining and recording key performance indicators on a weekly basis on areas such as restraint, wounds, medication monitoring, incidents and accidents. Regular audits were ongoing but staffing levels and time had not enable the implementation of actions and recommendations from these.

Overall the inspectors saw significant improvements in the overall governance and management of the centre through the addition of quality management systems and a management team with the knowledge to ensure compliance with the regulations to have a demonstrable effect on improving residents’ safety and quality of life within the centre.

The issues around the long term management of the centre and the recruitment of a provider nominee and person in charge require immediate action to ensure the improvement seen continue and progress.

**Judgment:**
Non Compliant - Moderate

**Outcome 03: Information for residents**
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided
for that resident and the fees to be charged.

Theme: Governance, Leadership and Management

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

Findings:
At the previous inspection, it was found that six residents did not have a written signed contract of care. On this inspection, it was seen by the inspectors that residents now had a written contract signed by the residents or their representatives. There was one exception to this with one resident, where there was evidence of letters of correspondence with the family requesting a returned contract of care, which demonstrated that all efforts were made to ensure that a signed contract was in place.

Judgment:
Compliant

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:
Since the last inspection the then new person in charge had resigned his post and left the centre three weeks prior to this inspection. The provider informed the inspectors that they were in the process of recruiting and appointing a new person in charge. There have been numerous changes to the person in charge since the Authority undertook its first inspection of the centre in 2009 and the inspectors expressed concern in relation to the ongoing changes to person in charge and the unsettling effect this has on continuity of care for residents and stability for staff.

The assistant director of nursing (ADON), who had significant experience in supporting residents with mental health needs, was acting as the person in charge at the time of the inspection and for the three weeks prior to the inspection. He told the inspectors that he was receiving significant support and guidance from the management consultants which gave him confidence to take on the role. The inspectors interacted with the current person in charge throughout the inspection process. There was evidence that the person in charge was engaged in the governance, operational
management and administration of the centre on a day-to-day basis. Inspectors were satisfied that he was a registered nurse, was suitably qualified and had a minimum of three years experience in nursing of the older person within the previous six years, as required by the regulations.

**Judgment:**
Compliant

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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

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

**Findings:**
At the previous inspection, improvements were required to some documentation to meet the requirements of Schedule 3 and 4 of the Regulations. For example, medicines administration records were not always accurately maintained.

At this inspection, a sample of documentation under Schedule 2, 3 and 4 of the Regulations was reviewed. Documentation reviewed met the requirements of Schedules 4, Medicines administration records were accurately maintained. However as will be discussed under medication management improvements were required in the format for recording as required medications.

Documents maintained under Schedule 2 required improvement the inspectors found that there was no vetting disclosure available for one member of staff, unidentified gaps were found in CV's and qualifications were not in staff files as required by schedule 2 of the regulations. The person in charge said he was aware of the shortcomings in relation to staff files and was currently implementing a system to ensure all the required documentation was available and a more robust recruitment system was implemented.

Documents under schedule 3 required review in that on the previous inspection the risk management policy for the centre stated that:“an incident report shall be completed by the staff member who identified the incident”. The assistant director of nursing at that time outlined that the centre had changed the way incidents were being reported and recorded from a paper system to an electronic system. However, care staff did not have access to the electronic system and had to report incidents verbally to nursing staff.
Either nursing staff or senior nursing management then had to complete the electronic record. This was not in keeping with the centre’s risk management policy. In addition, inspectors were not satisfied that this system could ensure that all incidents occurring in the centre were being accurately recorded and managed. On this inspection this practice had remained unchanged.

**Judgment:**
Non Compliant - Moderate

**Outcome 06: Absence of the Person in charge**

_The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/ her absence._

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The deputy person in charge was acting in the position of person in charge. At the time of inspection the position of deputy person in charge was not filled. Senior nurses formed part of the nursing complement and they took responsibility for care and welfare of residents when they were on duty.

**Judgment:**
Non Compliant - Moderate

**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:**
On a triggered inspection undertaken in October 2015 the Authority had received a concern in relation to moving and handling practices and potential issues of
safeguarding vulnerable adults in the centre. During that inspection there was evidence that all reasonable measures were not being taken to protect residents from abuse. The inspectors were informed that there was no overall system in place for tracking and managing allegations of abuse. This could not guarantee that the person in charge was aware of all allegations of abuse. Policies and procedures were in place for the prevention, detection and response to abuse which outlined that: “any staff member who receives information, suspects or is concerned that a resident has or is being abused or is at risk of being abused has a duty of care to report the matter as soon as possible.” However, there was evidence that incidents of potential abuse of vulnerable adults were not being reported by staff. Inspectors were not satisfied that staff understood the nature of abuse and that staff were fully aware of their responsibilities in the prevention, detection and reporting of abuse.

Since the last inspection the inspectors found that the management team had been proactive and a review of staffs understanding and awareness of abuse was undertaken by the management consultants highlighted that the previous training had not been effective enough to ensure that staff had a clear understanding of abuse and of their responsibilities and obligations. As a result safeguarding training was prioritised and the centre had employed the services of an external trainer who provided intense training to ensure that staff had a clear understanding of abuse and of their responsibilities and obligations. The trainer also provided training in managing responsive behaviours. Staff who had attended the training sessions reported a high level of satisfaction with the courses content and their learning outcomes from same. Staff interviewed on this inspection demonstrated a full understanding of their responsibility to report all allegations of abuse and stated the centre now had a policy of zero tolerance of abuse.

Since the last inspection a policy on the use of mobile phones in the workplace had also been put in place and enforced by the management team.

The person in charge maintained a restraint register as part of his quality monitoring system and key performance indicators. There was evidence that comprehensive assessments had been put in place for the use of bed-rails in the centre and the inspector reviewed the assessments which clearly outlined the rationale for the use of restraint and outlined alternative to restraints tried and reasons for non use of same. Comprehensive person centred care plans were seen to be in place for restraint usage. However there were inconsistencies found in that one assessment viewed that had not been completed to the same standard. The person in charge outlined how they were working towards getting all these aspects of care in place but acknowledged it was a work in progress.

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

Findings:
On a triggered inspection undertaken in October the Authority had received a concern in relation to moving and handling practices in the centre and it was found that improvement was required in moving and handling practices, incident reporting and fire safety. Also on the previous inspection by the Authority in September 2015 it was found that the moving and handling risk assessments were inadequate as they had not been developed with the input of a person competent in the area of moving and handling. On this inspection the inspectors viewed records available for residents with limited mobility or strength who required the use of a mobile hoist to transfer. The assessments had been reviewed by a competent person. The inspectors saw that residents moving and handling assessments including assessments completed by the physiotherapist and care plans to direct the care for residents with limited mobility, were seen discreetly displayed inside the wardrobe doors in residents’ bedrooms. This was to ensure all staff were familiar and had access to residents requirements in relation to mobility aids, hoist and hoist sling type. As discussed previously the external consultants had brought in the services of an external trainer/facilitator who was on site working with staff two to three days per week. She provided training, guidance/practice development on all aspects of care including correct moving and handling of residents, which staff reported has improved care provided to all. The physiotherapist attends the centre one day per week as well as providing group exercises he has completed individual assessments and reassessments on residents post falls. There were records to show that the hoists had been serviced six monthly as required.

On the inspection in October 2015 it was also observed that the main entrance/exit door was fitted with an electrically powered lock which automatically released when the fire alarm went off. This door also had a latch in place and a deadbolt which did not automatically release when the fire alarm went off. In relation to facilitating residents to exit in the event of a fire it was unclear why the deadbolt was also present on this door. On this inspection the inspectors saw that the deadbolt was decommissioned and removed.

At the previous inspections following the risk identified of residents’ at risk of falling down the stairs, temporary stair-gates had been installed. The inspectors observed that the gates at the top of staircases presented an additional risk of falls. The stair-gates were at waist level and could be easily opened or left open in error by a resident. In addition, two of three stair-gates had been installed mid-way across the top step, effectively reducing by half the space on which to stand on the top step. On this inspection the inspectors saw that full gates had been put in place at the top and bottom of the stairs and the inspectors saw that these were kept closed at all times. The staff informed the inspectors that stairs were only being used by the staff as there were two lifts available that residents preferred to use. At the previous inspection, it was identified that the system for reviewing the effectiveness of controls required review. Since that inspection, the risk register had been updated in February 2016 and was
found to be comprehensive, controls had all been reviewed and updated.

At the previous inspection, it was found that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were not implemented by staff. While the centre had an infection control policy in place, staff required training in relation to how to implement the procedures, including training in hand hygiene and how to prevent and manage healthcare associated infections. On this inspection the inspectors saw and staff confirmed that training on infection control and hand hygiene had been provided to staff on various and numerous dates since the last inspection. The external trainer/facilitator who was on site working with staff two to three days per week provided ongoing training, guidance/practice development on all aspects of care which included infection control and hand hygiene. Staff members were observed to comply with best practice in relation to the use of personal protective equipment (aprons and gloves). Hand hygiene gel dispensers were located at suitable locations throughout the premises and had been put in place in all resident bedrooms; inspectors observed staff using these hand sanitizers throughout the inspection. Hand hygiene and infection control audits had been commenced. However the inspectors observed there was no wash hand basin present in the laundry which is a requirement for good infection control practices. This is actioned under outcome 12 premises.

At the previous inspection, it was identified (under Outcome 12) that in a vacant double bedroom on the first floor of the West Wing, exiting in the event of an emergency necessitated climbing three steps, traversing a room and descending four steps to exit via the dedicated fire exit. As a result, no resident residing in this room would be able to have any degree of mobility or cognitive impairment and would need to be fully independent. The person in charge told the inspector that since the last inspection advice from a competent person in the area of fire safety was received and the bedroom was no longer going to be used for residents and the application for registration was now reduced from 42 beds down to 40 beds.

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

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

At the previous inspection, it was noted that references and resources were not complete to allow those administering medicines to confirm and identify individual medicines in the monitored dose system. The inspectors saw on this inspection that a new format of medicine administration records had been introduced which included identifiable information for each medicine in the monitored dose system. However there was no distinction on the administration charts between regular and as required medications which could lead to errors. The inspectors noted that staff transcribed medication prescriptions which were checked and signed by two transcribing nurses and then countersigned by the GP as required by best practice guidelines. However the inspectors noted that there were a number of antibiotics being administered to residents which were prescribed over the phone by the GP but were not signed by the GP within 72 hours as per the centres policy. Therefore medications were being administered without a valid prescription.

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

Judgment:
Non Compliant - Moderate

### Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective care and support

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

**Findings:**
There were a couple of different General Practitioner (GP) practices providing a service to the residents and residents’ health status was reviewed regularly, by the doctor including their medication.

Residents’ additional healthcare needs were met. Physiotherapy services were available once a week. If additional physiotherapy is required this is paid for privately. The chiropodist visited regularly and saw all residents as required. Dietician, speech and language and tissue viability services were provided by professionals from a nutritional company who were also contactable by telephone for advice as required. All residents
have regular nutritional screening and regular weight monitoring.

Optical assessments were undertaken on residents in-house by an optician from an optical company. Mental health services were provided by community psychiatric nurses who visited the centre and regular reviews by a psychiatrist. The inspectors were satisfied that facilities were in place so that each resident’s well being and welfare was maintained by appropriate medical and allied health care. Residents, where possible, were encouraged to keep as independent as possible and inspectors observed residents moving freely around the corridors.

At the previous inspections, it was found that a comprehensive assessment of residents' social care needs had not been satisfactorily completed for all residents and care planning required further improvement. On this inspection the inspectors saw that there was a comprehensive assessment of the residents social care needs undertaken. The inspectors met the full time activities co-ordinator who told the inspectors she is now fully supported in her role. She said she has been enabled to implement a wide variety of different activities into the activity programme including a number of one to one activities. She provided residents with opportunities to take part in every day household activities such as folding, pairing socks which some residents found very therapeutic. The inspectors saw a variety of activities taking place during the two day inspection which included gardening, music, dancing, art, reminiscence, old films and sing songs. The residents appeared to be participating fully and enjoying the activities. They told the inspectors they looked forward to the different activities.

Although the inspectors saw evidence that staff had in-depth knowledge of the residents and their needs, resident care plans did not always reflect this knowledge and the personalised care provided to the residents. On this inspection inspectors reviewed a number of care plans. Some care plans were individual, very comprehensive, specific and directed the care to be given to each resident. Other care plans either had not been developed for identifiable needs or did not adequately direct the care to be given to each resident. The centre had changed over to a computerised system of assessment and care planning and care plans were generated on the computer which the care staff did not have access to. Therefore care plans could not fully direct care as they were inaccessible to the staff providing the care. The person in charge said he was aware of this and was at times printed out the care plans and made them accessible to staff particularly if they were plans for the management of responsive behaviours to ensure continuity of care and in the case of moving and handling assessments and care plans which as discussed earlier were made available in residents rooms. The inspectors also saw that although wound dressings took place this was not always updated on the wound assessment chart. The shortage of nursing staff which is discussed further in outcome 18 contributed to the inconsistencies in assessment, care planning and documentation.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose
and meets residents’ individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
At the previous inspection, it was found that the premises did not fully meet the requirements under Schedule 6 of the Regulations. For example: in the communal area on the ground floor, there was an insufficient number of toilets; on the first floor of the ‘West Wing’ grab-rails had not been fitted in the shower of the unoccupied double room and the shower trays in every shower on this floor had a threshold step that residents had to step over to access the shower. In the (vacant) double bedroom in the West Wing, exiting in the event of an emergency necessitated climbing three steps, traversing a room and descending four steps to exit via the dedicated fire exit. As a result, no resident residing in this room would be able to have any degree of mobility or cognitive impairment and would need to be fully independent. On the first floor of the ‘East Wing’, screening in the two double bedrooms was inadequate. The layout of the bed in one double bedroom was not acceptable. The bedrooms on the first floor of the ‘East Wing’ were confined in terms of space and were not suitable for any resident who required assistive or adaptive mobility aids or appliances.

On this inspection, it was demonstrated that substantial progress had been made to address all of the failings identified at the previous inspection relating to the premises. During the inspection the inspectors saw that workmen were on site and two new assisted toilets and a fully assisted bathroom were very near completion on the ground floor. A new assisted toilet and shower was in operation on the first floor of the west wing.

With respect to the finding that shower trays in every shower on the first floor of the ‘West Wing’ had a threshold step that residents had to step over to access the shower. The inspectors saw that the shower trays had been removed and all now have a floor level access to the showers.

With respect to the (vacant) double bedroom in the West Wing, which was not suitable for any resident with a mobility or cognitive impairment, a written risk assessment had been completed. The provider and person in charge said that advice from a fire consultant was sought and the room has been taken out of use and the provider is now applying to register for 40 beds instead of the 42 originally applied for.

The layout of beds in one twin bedroom was not acceptable on the last inspection on the first floor of the ‘East Wing’, this was changed to a more appropriate layout on this
inspection. Screening in the two twin bedrooms was seen to be in place and was of a high quality to protect the privacy of the residents residing there. The inspectors also saw that privacy locks had been fitted to all en-suite bathrooms and to residents’ bedroom doors, grab rails had been put in place as required and there had commenced an ongoing programme of painting of rooms and general upgrading of the premises. On the previous inspection it was identified that the centre did not have suitable equipment to support residents with restricted mobility to have a shower or bath. New Equipment seen by the inspectors such as shower chairs, hoist slings, industrial cleaners and computer equipment had been purchased since the previous inspection. Overall the inspectors found the premises clean warm and comfortable.

On this inspection the inspectors did identify a number of chairs that had worn and torn upholstery that required repair or replacement. Also the floor covering in one bedroom on the ground floor on the east wing had numerous burn type marks on it and required replacement. As identified in outcome 8 a wash-hand basin is required in the laundry. Access to safe outdoor space continues to be an issue identified by the inspectors, residents, relatives and staff. There was a small courtyard accessible only through the smoking room and the floor surface here was not level in parts. The provider stated that they planned to provide an enclosed garden area at the side of the building where there was a covered in walkway with access to a garden. He stated this would be commenced once the other building work was completed.

The call bell system had been upgraded since the last inspection however the inspectors found that the new call bell leads had not been put into place in all rooms, the inspectors saw this had been rectified by the end of the second day of the inspection.

**Judgment:**
Non Compliant - Moderate

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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:**
At the previous inspection the inspectors identified there were minor issues with the complaints policy in that the inspectors observed that while the complaints procedure displayed prominently in the centre did outline the details of the nominated person, other than the person who maintained a record of all complaints in the centre, this change was not reflected in the complaints policy made available to inspectors. This was rectified on this inspection and an up-dated policy reflecting the name and contact
details of the acting person in charge was forwarded to the inspector following the inspection. The complaints log was examined and the nature and detail contained in the record complied with the requirements of regulations.

**Judgment:**
Compliant

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**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:**
At the previous inspection, it was identified that the screening in the two twin bedrooms was not adequate as screens were of a plastic material and were not sufficiently long from ceiling to floor. One screen did not fully close on one side. On this inspection the inspectors saw that high quality screening curtains had been put in place in the two double rooms which fully protected the privacy and dignity of the residents.

The inspectors were satisfied to see that improvements identified at previous inspections had continued such as regular residents meetings were being held. Inspectors reviewed minutes of the meetings and found that they were very relevant to issues in the centre, including what activities residents enjoyed, how they found the food and any aspects they would like addressed. There was evidence that residents’ views and opinions had been acted upon with the exception of the request from residents for trips out and access to outdoor space. This has been discussed and actioned under outcome 12 premises.

There was evidence of advocacy services provided and available for residents.

**Judgment:**
Compliant

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

**Findings:**
At the previous inspections, it was found that the centre’s training records showed that staff did not have up to date mandatory and additional training assessed as being appropriate to provide care to the residents. On this inspection, the inspectors were informed by staff and training records confirmed that there had been a substantial investment in staff training since the previous inspection. As discussed under outcome 7 training in safeguarding was prioritised and provided by an external trainer who also ran training programmes on managing responsive behaviours and dementia care and increasing staffs awareness of memory impairment and the effects on the resident. Staff who had attended the training sessions reported a high level of satisfaction with the courses content and their learning outcomes from same.

The external consultants had also brought in the services of an external trainer/facilitator who was on site working with staff two to three days per week. She provided training, guidance/practice development on all aspects of care from moving and handling, pressure area care, hygiene practices, infection control and focused on developing the skills of staff in providing care to the diverse client group of residents. The staff that spoke to the inspectors all highlighted how beneficial this has been for all staff and residents and staff reported feeling valued and invested in. Staff nurses who spoke to the inspectors said they could see the benefits and felt a much higher standard of care was now being provided to the residents and staff had a greater understanding of their roles and responsibilities. The provider assured the inspectors that this role was to continue.

The inspectors saw that numerous other formal training courses had been booked and were scheduled for the coming months. Training records confirmed staff had up to date moving and handling training and fire training. Other training provided in 2016 was complaints handling, continence care and providing information to residents.

Residents and relatives spoke positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspectors throughout the inspection in the dignified and caring manner in which staff interacted and responded to the residents.

On the previous inspections the inspectors expressed concern in relation to nurse cover and it was not demonstrated that arrangements in place in relation to the skill mix of staff were appropriate at all times to meet the needs of residents. There was only one nurse on duty from 08.00 to 20.00 to address all the nursing needs of the residents and to undertake three medication rounds throughout the day. Nursing staff reported having
to stay on duty late most evenings to complete their reports and documentation. There
were no contingencies for residents who became unwell or were at end of life. The
provider and person in charge said they were actively recruiting nursing staff and as
discussed previously had stopped taking admissions to ensure the service to residents
was safe. The inspectors also expressed concern in relation to the staffing levels at night
which reduced to one nurse and two care staff from 20.00hrs. The night time
medication round due to the complex medication regimes of many of the residents could
take up to two hours to complete. The nurse should not be disturbed during this
process. Due to the size and layout of the building over two floors it was not possible for
the remaining two staff to supervise the communal rooms and also assist residents to
bed some who may require the assistance of two staff. The person in charge said they
were looking to commence a twilight shift which would provide extra staffing cover but
this was not in place at the time of the inspection.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Caroline Connelly
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Cahermoyle House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000412</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>23/02/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>30/03/2016</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:
The issues around the long term management of the centre and the recruitment of a provider nominee and person in charge require immediate action.

1. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and...
details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
The position of PIC has now been filled. We are currently recruiting suitable candidates for the position of ADON or CNM and this is a priority for the Registered Provider. As an ongoing long term management plan we have re-engaged the services of the management consultants referred to in the report and they will continue to provide on-site support to the Provider Nominee and Person in Charge (where two consultants will be on-site two days per month).

Additionally, the external nurse facilitator (also referred to in the report), will continue for the long term to provide on-site training and education.

Proposed Timescale: As soon as possible. External support – immediate.

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

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**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:**
Documents maintained under Schedule 2 required improvement the inspectors found that there was no vetting disclosure available for one member of staff, unidentified gaps were found in CV’s and qualifications were not in staff files as required by schedule 2 of the regulations.
Inspectors were not satisfied that this system of electronic documentation of incidents by nursing staff only could ensure that all incidents occurring in the centre were being accurately recorded and managed.

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:**
All staff files have been audited. Requests for staff to provide missing documentation have been distributed. Missing documentation is being gathered and staff files are currently being updated. Henceforth all documentation required under the regulations will be gathered through a more robust recruitment process.

In compliance with the Cahermoyle House risk management policy, incident reports in paper form are now freely available to allow all staff to report any incident accurately and in their own words. In keeping with the policy, an electronic incident report will then be commenced by the nurse on duty.

**Proposed Timescale:** 30/04/2016
Outcome 06: Absence of the Person in charge

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The deputy person in charge was acting in the position of person in charge. At the time of inspection the position of deputy person in charge was not filled. Senior nurses formed part of the nursing complement and they took responsibility for care and welfare of residents when they were on duty.

3. Action Required:
Under Regulation 33(1) you are required to: Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 33(2).

Please state the actions you have taken or are planning to take:
A PIC has now been appointed.
We continue to actively seek an ADON or CNM.
We continue to actively seek further staff nurses.

Proposed Timescale: Recruitment ongoing until vacancies filled.

Proposed Timescale:

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 were inconsistencies found in that one assessment for restraint viewed had not been completed fully and did not identify alternatives to restraint tried. The person in charge outlined how they were working towards getting all these aspects of care in place but acknowledged it was a work in progress.

4. 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:
All restraint assessments are now completed. Where appropriate, alternatives to restraint which have been considered or tried are documented.
Proposed Timescale: 23/03/2016

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors noted that there were a number of antibiotics being administered to residents which were prescribed over the phone by the GP but were not signed by the GP within 72 hours as per the centres policy. Therefore medications were being administered without a valid prescription.

5. 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:
A new protocol has been implemented to ensure that all medication changes are now signed by the GP within 72 hours as per policy.

New medication prescription charts and recording sheets are being introduced which will clearly distinguish between regular and “as required” medication. This new system will be implemented at the beginning of the next medication cycle on 31/03/16. On introduction of the new system, weekly medication chart audits will be carried out for 4 weeks to assess any issues in the transition. Audits will be carried out monthly thereafter.

Proposed Timescale: 31/03/2016

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:
There were inconsistencies in some residents assessments and care planning documentation and care plans could not fully direct care as they were inaccessible to the staff providing the care.

6. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).
Please state the actions you have taken or are planning to take:
A complete re-evaluation of assessment and care planning documentation is being carried out to ensure consistent quality. As identified in the report, we do not currently have our full complement of nursing staff, therefore the PIC will carry out the re-evaluation.

It is planned that the assessments and care plans will be fully completed for 10 residents by 29/04/16; with a further 10 full sets of assessments and care plans being completed by 30/05/16 and all remaining assessments and care plans completed by 30/06/16.

Proposed Timescale: 30/06/2016

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspectors identified a number of chairs that had worn and torn upholstery that required repair or replacement.
The floor covering in one bedroom on the ground floor on the east wing had numerous burn type marks and required replacement.
A wash-hand basin is required in the laundry
Access to safe outdoor space continues to be an issue identified by the inspectors, residents, relatives and staff. There was a small courtyard accessible only through the smoking room and the floor surface there was not level in parts. Further enclosed outdoor space was required.

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

Please state the actions you have taken or are planning to take:
A review of all of all chairs and seating will be undertaken and any that require repair will be undertaken or removed from use.

New floor covering in the room on the East Wing will be replaced. A wash hand basin will be installed in the laundry room. In relation to additional outdoor space an area has been identified and will be secured to allow safe access for residents.

Proposed Timescale: Repair work 30/04/2016, outdoor space 30/06/2016

Proposed Timescale: 30/06/2016
Outcome 18: Suitable Staffing

Theme: Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not demonstrated that arrangements were in place to ensure the skill mix of staff were appropriate at all times to meet the needs of residents. There was only one nurse on duty from 08.00 to 20.00 to address all the nursing needs of the residents and to undertake three medication rounds throughout the day. There were no contingencies for residents who became unwell or were at end of life.
The inspectors also expressed concern in relation to the staffing levels at night which reduced to one nurse and two care staff from 20.00hrs. The night time medication round due to the complex medication regimens of many of the residents could take up to two hours to complete. The nurse should not be disturbed during this process. Due to the size and layout of the building over two floors it was not possible for the remaining two staff to supervise the communal rooms and also assist residents to bed some who may require the assistance of two staff.

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

Please state the actions you have taken or are planning to take:
We continue to actively seek further staff nurses to provide two nurses on duty from 08.00 to 20.00 daily. In the interim, where available, we will support staff with the use of agency nurses.

A “twilight” shift has now commenced which ensures that an extra member of staff is now present between 20.00 and midnight.

Proposed Timescale: 30/03/2016