# Compliance Monitoring Inspection report

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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Croft Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000028</td>
</tr>
<tr>
<td>Centre address:</td>
<td>2 Goldenbridge Walk, Inchicore, Dublin 8.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 454 2374</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:croft@silverstream.ie">croft@silverstream.ie</a></td>
</tr>
<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>Croft Nursing Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Joseph Kenny</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Siobhan Kennedy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Nuala Rafferty</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>37</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</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: 02 August 2016 09:30 To: 02 August 2016 19:30

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

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<td>Compliant</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Major</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 14: End of Life Care</td>
<td>Substantially Compliant</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
Regulatory Enforcement Proceedings (regulatory meeting followed by the issuing of a warning letter on the 6 May 2016) were initiated by the Authority as it was found during previous inspections (18 August 2015 and 30 March 2016) that the designated centre was in contravention of the Health Act 2007, as amended, and regulations made there under. In particular, the premises of the designated centre were not appropriate to the number and needs of the residents in accordance with the statement of purpose. The Authority had been informed that plans had been drawn up with a view to extending the centre with additional bedrooms, communal space, storage and bathroom facilities and that planning permission had been sought. However, written confirmation regarding the details of the plan, timescales of the stages of the plan, completion of work and funding details had not been forwarded to the Authority.
The purpose of this monitoring inspection was to determine the progress made in relation to the extension of the premises and the matters arising from the inspection of the designated centre carried out on the 30 March 2016. These matters related to governance and management, safeguarding, health and safety, medication management, health and social care, residents rights, and staffing.

The inspection process included a review of documentation, observation of practices communication with residents, relatives and staff. Thirty seven residents were being accommodated on the day of the inspection with no vacancies.

Since the last inspection a new person in charge had been recruited and there was evidence that progress had been made in relation to a number of areas of major and moderate non-compliances. For example the following matters had been progressed:

- An annual review of the quality and safety of care delivered to residents had been compiled for 2015 and statistical information and the views of residents and relatives were being gathered and analysed to prepare the annual review for 2016.
- A monitoring system was in place in respect of the use of restraint and this included risk assessments and information in residents’ care plans to guide staff. Appropriate equipment had been put in place to control the risk of entrapment while using bedrails.
- Documentation was available in respect of all of the residents with regard to the risk of an unexplained absence of any resident and staff who spoke with the inspectors were aware of the procedures to be followed.
- The majority of staff had participated in training in the protection of residents from abuse and the staff who communicated with the inspectors were able to demonstrate their knowledge in this area.
- A redecoration programme of the premises was in place.
- The provider gave the inspectors a copy of the proposed improvements (alterations and an extension to the existing nursing home) to be made to the premises which included notification by the planning department of the decision to grant permission for these works which was received subject to conditions on 27 June 2016. The provider anticipates that this work will be completed by 1 November 2017. The designated is registered to accommodate 38 residents, however, due to the shortcomings in the environment approval from the Authority has been granted to accommodate no more than 37 residents.

The views expressed by residents and relatives to the inspectors in respect of the facilities and services and care provided were satisfactory.

Overall, the inspectors found that the provider did not ensure that there were sufficient resources to ensure the effective delivery of care and appropriate management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored. In addition, appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines was not provided in respect of a resident’s care. The resident’s needs were not fully assessed prior to or following admission and so an appropriate care plan had not been implemented. Medication management systems did not protect the resident.
This necessitated the issuing of two immediate action plans in respect of governance and management and health care during the post inspection meeting. The provider’s response in consultation with the management team confirmed that an additional staff member would be on duty with immediate effect from 20:00 hours to 08:00 hours for initially a period of 3 nights with a full and comprehensive action plan to mitigate against the risks identified to be submitted to the Authority on or before 5 August 2016.

Inspectors saw residents engaging in general and personal routine activities, for example getting up, washing and dressing and having snacks and meals and while there were group led social and recreational activities and one-to-one sessions with some residents, in the main, residents did not have opportunities to participate in meaningful activities, appropriate to their interests and preferences.

The inspectors noted that the health and safety of residents, visitors and staff were not fully promoted and protected particularly from the risk of fire.

The findings of the inspection have identified major non-compliances with the Health Act 2007 (Care and Welfare of Residents in Designated centres for Older People) Regulations 2013 and the action plan of this report identifies the requirements to be addressed.
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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The matter arising from the previous inspection related to the lack of consultation with
residents and relatives in preparation of the annual review.
The inspectors learned that a residents’ committee meets on a monthly basis and these
views influence the day-to-day management of the centre and contribute to the annual
review. A relative’s information and support group meets on a quarterly basis and these
views are monitored in order to assist in compiling the annual review report. Both
forums are facilitated by the residents’ advocate.
The person in charge informed the inspectors that currently statistical information and
the views of residents and relatives are being gathered and analysed in preparation of
the annual review for 2016.

The inspectors saw that there was a clearly defined management structure that
identifies the lines of authority and accountability specifies roles and details
responsibilities for all areas of care provision. The person in charge is supported by the
provider, a general operations manager, a group support nurse manager, an assistant
director of nursing, an information technology/risk manager, an administrator, nursing
and health care staff and catering, household and maintenance staff.

While the person in charge showed the inspectors evidence whereby she was in the
process of introducing management systems to monitor the quality and safety of care
delivered to residents, for example, monitoring instances of restraint and pressure sores
overall, the inspectors found that the management systems in place in the centre were
not sufficient to ensure the service provided was safe, appropriate, consistent and
effectively monitored. A review of care planning documentation showed that the
systems in place were ineffective with regard to the following matters:
• The pre-assessment of a resident’s care was not conducted with regard to the
suitability of the placement, meeting the individual and collective needs of residents,
sufficiency and competencies of staff to meet the residents’ needs and the provision of a safe environment.

- The post-assessment of a resident was incomplete and therefore there was no care/treatment plan to meet all of the resident’s needs.
- Medicinal products dispensed to a resident were not appropriately administered.
- Timely referral of residents’ care to medical and Allied health professionals.
- Appropriate responses to behaviours that are challenging.

There were insufficient resources to ensure the effective delivery of care and support as staff did not meet the needs of all of the residents. Inspectors found that management and staff did not respond to behaviours that were challenging or posed a risk to the resident or other residents/persons in the designated centre.

As a result of the above findings an immediate action plan in respect of insufficient resources and ineffective management systems (Regulation 23 (a) and (c)) was issued to the provider. The provider’s response in consultation with the management team confirmed that an additional staff member would be on duty with immediate effect from 20:00 hours to 08:00 hours for initially a period of 3 nights with a full and comprehensive action plan to mitigate against the risks identified to be submitted to the Authority on or before 5 August 2016.

Judgment:
Non Compliant - Major

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

Theme:
Governance, Leadership and Management

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

Findings:
The contract of care for 2 residents was reviewed and the fees for services charged had not been included in the contract. The inspectors heard that new contracts had been issued and representatives of the 2 residents did not wish to engage in the new process. Management agreed to update the residents’ contracts with this information.

Judgment:
Substantially 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:**
The person in charge commenced employment on the 12 April 2016, however, was absent for a period and returned to work on the 12 July 2016.

The person in charge is a qualified registered nurse and has experience of working with older persons. She has the authority and is accountable and responsible for the provision of the service within her remit as person in charge. Some staff who communicated with the inspectors described some of the measures which she had introduced to improve the service. For example implementing safe moving and handling practices.

During the inspection process she demonstrated that she had knowledge of the regulations and standards governing nursing and residential care and had relevant information pertaining to the care and condition of residents in the centre. She and the staff team facilitated the inspection process. Staff confirmed that good communications exist within the staff team and residents, relatives and staff were aware of her role.

**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.

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**Theme:** Governance, Leadership and Management

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

**Findings:**
The documents to be held in respect of 2 staff members in accordance with schedule 2 were not up-to-date in respect of gaps in their employment history and Garda vetting.

**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:**
The matter arising from the last inspection related to the risk assessment for restraint and the processes in place for the safe and appropriate use of bed rails. The inspectors saw that this matter had been satisfactorily actioned. Bedrails and bumpers were in place for 6 residents and all of these residents had an assessment and alternatives tried prior to the use of bedrails. Two residents requested the use of bedrails. An assessment was carried out for a resident using a lap belt. From an examination of some of the bedrails inspectors saw that these were fitted properly.

The inspectors were informed that a number of new low low beds and new mattresses suitable for use with pressure relieving mattresses had been purchased.

Some staff who communicated with the inspectors confirmed that there was a policy and procedure in place for the prevention and detection and response to abuse. They described the different types of abuse and reporting procedures and what to do in the event of a disclosure about actual, alleged, or suspected abuse. Since January 2016 the training records provided to the inspectors identified that 23 staff had participated in the protection of residents from abuse training, however, training has expired for 5 persons working at the designated centre.

The inspectors reviewed care planning documentation and saw that management and staff did not respond to behaviours that were challenging or posed a risk to the resident or other residents/persons in the designated centre in spite of the fact that the provider’s response to the previous action required identified that behavioural incidents would be reviewed to assure the management team that the procedures were being followed.

The staff did not have up-to-date knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging as inspectors read about the fear that staff had in particular situations and an examination of the training records showed that none of the staff had training in responding to challenging behaviour since August 2014.

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

**Theme:**
Safe care and support

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

**Findings:**
This outcome was not fully inspected, however, obvious health and safety issues identified during the inspection have been reported on.

The matter arising from the previous inspection related to the missing persons folder not having been updated for a recently admitted resident to the centre. Since the last inspection the Authority had been notified of a further unexplained absence by a resident from the centre. The inspectors reviewed this notification and found that the person in charge had put in controls to mitigate against any future re-occurrence of such an incident. This included monitoring of the main entrance door to the centre, updating all of the information relevant to each individual resident including a recent photograph and communication and discussions with staff members in respect of the policy and procedures. Staff who communicated with the inspectors in respect of this matter were knowledgeable of the procedures. A documented system of staff checks was in place including checks of exit points and frequent checks on the residents. The person in charge informed the inspectors that the risk management policy had been updated to reflect the recent measures and actions in place to control the risk of the unexplained absence of any resident.

Arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents was not in place as inspectors identified during the inspection that medicines were not administered per the prescriber for example the dosage prescribed was not consistently administered. Management agreed to investigate this serious incident and forward a copy of the investigation and findings to the Authority.

The following risks were identified by the inspectors:

- Maintenance tools (electric drill with a bit inserted and stepladders) were left in a residents' bedroom during periods when the residents were occupying the bedroom.
- Linen trolleys were stored in the corridors blocking handrails.
- Residents' personal and confidential information was not stored securely.
- Cleaning equipment was left unattended/stored in hallways and corridors.
- Examination of the training records provided to the inspectors on inspection identified that a nurse and 4 care staff rostered for duty did not have up-to-date training in moving and handling.
- Residents found it difficult to access seating in the main communal sitting room due to
the congestion in the area with mobility aids and furniture. The inspectors observed two residents having difficulty, one manoeuvring tables while still using a mobility aid to find a seat and another resident who had to exit the room to receive a visitor in private had to move mobility aids and tables from the exit route.

Procedures, consistent with the standards for the prevention and control of healthcare associated infections were not fully implemented as a toilet facility was not clean, some sanagenic containers used for the disposal of soiled incontinence products were overflowing or not closed properly and the cleaning schedule had not been kept up-to-date. The training records identified that 7 staff members had participated in infection-control during the period 2008 until 2012. No staff member has participated in this training since 14 November 2012.

Adequate precautions against the risk of fire had not been fully implemented as follows:
- Fire doors in high risk areas such as the laundry room, the kitchen designated smoking room and some residents’ bedroom were held open either with door wedges or furniture.
- Double doors on the corridor leading from the kitchen/dining room towards the designated smoking room did not have hold open magnetic devices attached to the fire alarm system which would close in the event of an emergency. These doors remained open for most of the period of the inspection.
- A fire exit in the communal sitting room was blocked with sitting room chairs.
- A final fire exit which had a keypad installed close to the door was obstructed by the positioning of a foam fire extinguisher and 4 fire rescue mats which also obstructed the use of the handrail.
- The emergency fire signage at a fire exit was cracked.
- Arrangements had not been made for all staff to receive suitable training in fire prevention and emergency procedures as the training records provided to inspectors on inspection identified that the training had expired (since February 2012 and May 2013) for 17 staff members who are rostered on duty. The designation of staff members include a staff nurse and a care assistant working on night duty, care assistant on day duty, catering, laundry and administration staff.

**Judgment:**
Non Compliant - Major

**Outcome 09: Medication Management**
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.
Findings:
The matters arising from the previous inspection related to the following: –
• Medication competency assessments.
• The administration of crushed medicines.
• Having sufficient nutritional supplements available for residents and informing the prescriber if alternative supplements are being used.
• Medication administration records for insulin being signed by staff before administration of the prescribed dose of insulin to the resident.
• Review of medication prescription and administration.
• Addressing the issues identified by the audit carried out by the pharmacist.
• Carrying out medication drug round audits.
• Administering medicines from a prescription sheet which had not been signed by the prescriber within the required timescale.

The inspectors found that while some of the above matters had been addressed each resident was not protected by the designated centre’s policies and procedures for medication management.

The training records provided to the inspectors showed that 13 out of the 16 staff nurses working at the designated centre had participated in training in the period from February to June 2016 and only one of the staff nurses who did not participate in training in 2016 was rostered to work in the designated centre. Despite staff having participated in training inspectors identified the following issues:
• Medicines were not administered per the prescriber for example the dosage prescribed was not consistently administered. See outcome 8 for action plan.
• Medicines were administered from a photocopy and or an unsigned pharmacy prescription and the original was not available.
• Medicines were covertly administered.
• It was not possible to reconcile the number of tablets administered as PRN from the blister pack against the recordings in the administration sheet.
• The administration of medicines was outside the prescriber timeframe and the actual time of administering was not recorded.
• Recordings made by the staff nurses administering medicines were difficult to read with regard to comments such as residents refusing medicines.

Judgment:
Non Compliant - Major

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:**
The matter arising from the previous inspection highlighted that care plans were not consistently updated with recommendations from Allied healthcare professionals. The person in charge in response to the action required highlighted that this matter would be raised at team meetings with staff nurses and that "care plan training has been arranged for staff nurses" to be provided by the group trainer. Inspectors saw evidence in residents' care plans regarding recommendations made by Allied health professional and saw that these were implemented. However, only two staff members had participated in care plan training this occurred on 9 March 2011 and 10 September 2014. See outcome 18 for action plan in respect of training.

Overall inspectors found that each resident’s well-being and welfare was not maintained by a high standard of evidence-based nursing care and appropriate medical and Allied health care and this was particularly relevant for a resident who was recently admitted to the designated centre.

The pre-assessment information did not take account of all of the information available and supports that were in place in order to replicate these arrangements to meet the resident’s assessed needs in the designated centre.

Subsequently the post-admission assessment within the designated centre was not sufficiently comprehensive and did not assess all of the resident’s needs.

With the result the care and treatment plans were not drawn up in an individual care plan that reflected the resident’s needs, interests and capacities.

In addition, referrals had not been made to the resident’s GP and Allied health professionals to review the resident’s care in a timely manner.

As a result of the above findings an immediate action plan was issued to the provider in respect of not providing appropriate medical and Allied health care, including a high standard of evidence-based nursing care in accordance with professional guidelines (Regulation 6 (1). The provider’s response in consultation with the management team confirmed that an additional staff member would be on duty with immediate effect from 20:00 hours to 08:00 hours for initially a period of 3 nights with a full and comprehensive action plan to mitigate against the risks identified to be submitted to the Authority on or before 5 August 2016.

**Judgment:**
Non Compliant - Major

**Outcome 12: Safe and Suitable Premises**
The location, design and layout of the centre is suitable for its stated purpose and meets residents’ individual and collective needs in a comfortable and
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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
The design and layout of the centre was not suitable for its stated purpose and did not conform to the matters set out in regulation 17 schedule 6 of the Health Act 2007 as identified in previous inspection reports (20 August 2014, 18 August 2015 and 30 March 2016).

The designated centre is a single storey detached building and is registered to accommodate 38 residents, however, approval from the Authority has been granted to accommodate no more than 37 residents.

The communal facilities comprise of a dining room, sitting room, conservatory and dedicated smoking room. On the day of the inspection, primarily residents congregated in the main communal day room which was, at times, congested with mobility equipment and furniture. In general, the conservatory area was only used for recreational purposes and by a limited number of residents and staff members facilitating the social programme.

Bedroom accommodation consists of 10 single rooms, 12 twin-bedded rooms and one multi-occupied bedrooms accommodating 3 residents (1 resident’s bedroom accommodation is subdivided by a curtain).

Six of the single bedrooms had en suite shower and toilet facilities. None of the en suite toilet facilities were wheelchair and hoist accessible and were only suitable for independently mobile residents or those using walking frames with staff assistance.

There were three assisted shower rooms, two with toilets, which were wheelchair and hoist accessible. In one part of the centre nine residents had nearby access to two toilets, with the nearest shower facilities and further toilets accessible by crossing the main dining room.

There was an enclosed garden to the rear of the centre with grassy areas and safe walkways. There was also a patio area with garden furniture, enclosed by stone walls and surrounded by flower beds and a herb garden.

The centre had suitable heating and lighting.
There was evidence of on-going maintenance and refurbishment as a redecoration of the bedrooms as required in the previous inspection was in progress.

Storage facilities in the centre were insufficient to appropriately store equipment such as hoists, trolleys, chairs, and wheelchairs. There was no space available in the centre other than residents’ bedrooms to store commode chairs during the day, resulting in commode chairs being present in bedrooms throughout the day and night.

The three bedded room was not suitable to meet residents' needs in terms of privacy and dignity as only a curtain divided one resident from the other 2 residents which meant that visitors and staff used the twin room to access the single accommodation.

The provider gave the inspectors a copy of the proposed improvements (alterations and an extension to the existing nursing home to include additional bedrooms, communal space, storage and bathroom facilities) to be made to the premises which included notification by the planning department of the decision to grant permission for these works which was received subject to conditions on 27 June 2016. The provider anticipates that this work will be completed by 1 November 2017. The inspectors requested that this information is submitted to the Authority.

Inspectors noted that the flooring was stained at the toilet base in a shower room and the floor covering was ill fitting up the wall.

**Judgment:**
Non Compliant - Major

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**Outcome 14: End of Life Care**

*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

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

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

**Findings:**
This outcome was not fully inspected, however, the matter arising from the previous inspection was reviewed and found to be not fully implemented as the person in charge informed the inspectors that 19 of the 37 residents had an end of life care plan in place.

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

**Findings:**
This outcome was not fully inspected as inspectors focused on reviewing the progress in relation to the matter arising from the previous inspection. This related to the limited provision of one-to-one individualised activities based on residents’ individual interests and capacities particularly for those residents with cognitive impairment and or limited mobility.

The response from the provider in respect of the required action stated that the group trainer was in the process of providing all staff in the designated centre with dementia training. An examination of the training record provided to the inspectors showed that 16 staff had participated in dementia training since January 2016.

An activity coordinator was employed to work in the designated centre Monday to Friday 10:00 hours to 15:00 hours not including bank holidays. There was an activities programme in place with activities such as baking, arts and crafts, fitness classes, aromatherapy, Sonas and sing along scheduled to occur between 10am and 3pm Monday to Friday. One to one therapies were scheduled by the activities co-ordinator on a daily basis for a one half hour time slot before lunchtime. However, there were no scheduled activities for evenings or weekends.

On the day of the inspection some residents were observed to participate in a sonas programme and a karaoke session facilitated by the activities co-ordinator.

However, inspectors observed a 30 minute period between 10:30 and 11:00 hour whereby a musical video was playing on the television monitor but the seating arrangements did not assist all of the residents to see the monitor. One resident independently was singing to the music, however, there was limited engagement between staff and residents to enjoy the music. During this period a resident was awakened and moved from the sitting chair to allow another resident who had entered the room to sit in this particular chair. At one point, a staff member entered the room and engaged with each individual resident and it was notable the delight experienced by the residents from this interaction.

During another period in the afternoon from approximately 14:35 to 15:50 hours there
were no activities for 20 residents who were sitting in the main communal sitting room, yet at one point there were 5 staff members in the room but there was no/limited engagement with residents.

The person in charge acknowledged that this aspect of care provision required further improvement.

**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

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

**Findings:**
The matters arising from the previous inspection related to providing training to ensure that appropriate standards of care were met in the areas of medication management, bedrail risk assessments, policy on restraint and person centred care.

Inspectors found that staff had participated in medication management, however, systems and practices were still not in place to protect residents. See outcome 9 for details and action plan.

The person in charge had communicated during meetings with staff about the restraint policy and procedure, bedrail risk assessments and emphasised the meaning of person centred care. During communications with the inspectors staff members demonstrated their knowledge in these areas and were familiar with the needs of the residents, and provided care in a considerate and respectful manner. The inspectors observed that the interactions between staff and residents were courteous, caring and respectful. A staff member who communicated with the inspector was fully aware of the meaning of person centred care. She described residents' right to privacy and dignity, independence and choice.

Inadequate supervision of practice had been identified in previous inspections of the
centre (18 August 2015 and 30 March 2016). However, the actions taken to date, for example induction training, probationary periods for staff, staff appraisals and observations of care practices had not fully addressed the matter as reported upon in outcome 9 medication management and outcome 11 health and social care needs, whereby poor practices were being implemented by staff in respect of a resident’s care but had not been identified by the supervision process.

An examination of the duty roster showed that on the morning of the inspection there were 6 staff nurses on duty, including the person in charge. Four of these staff nurses were supernumerary. The roster identified that staffing levels at night time consisted of a staff nurse and 3 care assistants. The staffing levels and competencies of staff were insufficient to meet the needs of the current resident group. See outcome 2 for details. There was an on call roster for directors of nursing within the group to provide support if and when necessary.

The senior management in the centre consisted of the person in charge (director of nursing), acting director of nursing and a senior clinical nurse manager.

From an examination of the training record provided to the inspectors it was noted that all staff had not participated in mandatory training as reported upon in the relevant outcomes and the following information highlights that staff did not have access to appropriate training in accordance with their role and designation as follows:

- In 2014 two nursing staff members received training in wound care and in February 2016 the current person in charge participated in this training.
- In June 2013 one staff nurse participated in training in venepuncture.
- On the 5 February 2016 only one staff member, the person in charge attended training in nutritional screening.
- On the 9 March 2016 only one staff member, the person in charge attended training regarding incontinence care.
- Four staff members participated in hoist training on the 14 March 2014.
- During the period between 2013 and 2015 catering staff attended food safety training. The person in charge and a staff member performing cleaning duties attended this training on the 4 May 2016.
- A staff member participated/completed Fetac level V on the 16 December 2013.
- A care staff member attended training regarding the care of the elderly on the 16 December 2015.
- Thirteen staff members participated in training regarding falls prevention and restraint during July 2011.
- Seven staff members participated in end of life training on the 3 February 2015.
- Nine staff members participated in first aid during 2016.
- Two staff nurses participated in the care planning training: one on the 9 March 2011 and the other on the 10 September 2014.

Judgment:
Non Compliant - Major
**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Siobhan Kennedy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>The Croft Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000028</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>02/08/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>28/10/2016</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:
There were insufficient resources to ensure the effective delivery of care and support as staff levels and competencies did not meet the needs of all of the residents, particularly residents displaying behaviours that are challenging.

1. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
The Registered Provider is committed to ensuring that the resources are made available to the PIC to ensure that the needs of all residents are met.

The admissions policy will be reviewed and amended if needed to ensure that it guides the PIC and/or any staff involved in the pre and post admission of a resident in how best to ensure that the placement is suitable and can meet the individual needs of the proposed resident, taking into consideration the residents already living within the centre.

The PIC, in accordance with the Health Act, does has the autonomy and the authority to agree that the placement of a resident is suitable or not.

The PIC is satisfied that the liaison person has the necessary skills and is an appropriate healthcare professional to carry out a comprehensive assessment. Following the comprehensive assessment, the PIC will:

(i) carry out a risk assessment to identify if there are any additional concerns, medical illnesses (including responsive behaviours) which may impact on the placement. Where additional resources (including equipment and manpower) are required, these will be identified and agreed with the RP prior to admission;

(ii) review the existing staffing levels using an acuity and ratio based tool and will determine if the existing levels will support a new admission;

(iii) review the current training status of staff to determine whether or not additional support and/or training is required to support the placement.

The PIC will ensure that the care plan is prepared within 48 hours of admission. Where a resident is admitted with a current or past history of responsive behaviours a record will be kept which will allow staff to identify presenting behaviours, potential triggers, the consequence of behaviours and which interactions the resident responds better to. Once this information is available, the care plan can be developed. With the residents’ agreement, input will be sought from them and their family. The PIC will ensure that for all new admissions that the care plan will be reviewed and updated on a weekly basis for the first month to ensure that it adequately guides staff. It clearly identifies residents’ needs and guides staff in how best to meet these needs.

The PIC will continue to monitor this “settling-in” phase and will discuss with the RP if any other resources are required and will ensure that where necessary all referrals to medical/allied health professionals are made in a timely fashion.

The PIC will arrange for a review of the current medication management systems to identify if there are system failures and will develop an action plan to address these to ensure that the system in place for the management of medications is safe and appropriate.
With regard to any of the measures outlines above, where the PIC identified a requirement for additional resources the RP is committed to working with the PIC to ensure that these resources are made available.

Pre admission risk assessment–26/10/2016
Review training status –26/10/2016

Proposed Timescale: 30/11/2016
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems in place in the centre were not sufficient to ensure the service provided was safe, appropriate, consistent and effectively monitored. A review of care planning documentation showed that the systems in place were ineffective with regard to the following matters:
- The pre-assessment of a resident’s care was not conducted with regard to the suitability of the placement, meeting the individual and collective needs of residents, sufficiency and competencies of staff to meet the residents’ needs and provision of a safe environment.
- The post-assessment of a resident was incomplete and therefore there was no care/treatment plan to meet all of the resident’s needs.
- Medicinal products dispensed to a resident were not appropriately administered.
- Timely referral of residents’ care by medical and Allied health professionals.
- Appropriate responses to behaviours that are challenging.

2. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The RP is committed to ensuring that the management systems within the centre and the group are not only sufficient but effective, deliverable and achievable. The PIC is invested with the autonomy to manage the centre in accordance with the statutory obligations and will be supported to do this by the group.

The PIC will ensure that the admission policy is implemented in practice.

The PIC will ensure that pre and post admission and care planning is part of the quality monitoring programme so that he/she is assured that the policy is implemented fully in practice and will ensure that all regulatory requirements are met.
There is already a care plan auditing system in place whereby a percentage of care plans are audited monthly. The PIC will ensure that where there is a new resident that their care plan is audited as a part of this process.

The PIC is satisfied that she has the necessary knowledge and skills to be able to determine the quality of the care plans to ensure that they adequately reflect the current status of residents, residents care needs and to be able to determine the plans of care adequately address residents’ needs.

The PIC has arranged update training for all staff nurses which included their accountabilities and responsibilities in terms of documentation and in future where needs are identified she will arrange further for nurses to have additional training in care planning. The PIC will on an ongoing basis provide support and guidance to nurses in how best to develop and maintain care plans.

The PIC will arrange for a review of the current medication management systems to identify if there are system failures and will develop an action plan to address these to ensure that the system in place for the management of medications is safe and appropriate.

The in house trainer has developed a two day training programme which includes understanding dementia and responding to behaviours that challenge. Once all staff have attended this course the PIC will arrange for a post training analysis to determine staffs understanding and knowledge of responsive behaviours to ensure that they have the necessary skills to appropriately and effectively support residents who present with behaviours that challenge. Should further needs be identified, further training will be arranged.

The PIC is aware that the group is there to support her to be effective in her role.

Proposed Timescale: Admissions policy review and amendment and implementation 31/12/2016.
Auditing new admissions – 10/12/2016.
Next care plan audit due 10/11/2016.
Care plan training – 26/10/2016.
Post training analysis to be complete – 16/12/2016.

**Proposed Timescale:** 31/12/2016

**Outcome 03: Information for residents**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The contract of care for 2 residents was reviewed and the fees for services charged had
not been included in the contract.

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

**Please state the actions you have taken or are planning to take:**
There is a Contract of Care for all residents. There are a number of residents on schemes other than Fair Deal, information/letter will be provided to these in relation to additional fees and once we receive a response this information will be added to the resident file.

**Proposed Timescale:** 26/10/2016

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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:**
The documents to be held in respect of 2 staff members in accordance with schedule 2 were not up-to-date in respect of gaps in their employment history and Garda vetting. The senior clinical nurse manager's designation and hours of work was not identified on the staff roster.

4. **Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

**Please state the actions you have taken or are planning to take:**
The outstanding two Garda vettings have been obtained. In future, all garda vettings will be obtained before an employee commences work.

The curriculum vitae has since been updated and the gap has been explained satisfactorily.

The PIC will ensure that in future all gaps identified in cvs are adequately addressed.

**Proposed Timescale:** 26/10/2016

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The staff did not have up-to-date knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging as inspectors read about the fear that staff had in particular situations and an examination of the training records showed that none of the staff had training in responding to challenging behaviour since August 2014.

5. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
All staff currently employed in the centre have now had recognising and responding to abuse training. When staff members have been on planned leave (maternity) training will be done on their return.

The appointed in-house trainer has developed a two day training programme which includes understanding dementia and responding to behaviours that challenge. Of the current staff employed 50% have completed the course and the remaining 50% will have completed this by end of November.

The procedure for reporting all incidents of challenging behaviour has been reviewed and currently all incidents of responsive behaviours where a resident presents as challenging are to be recorded on the incident/accident report. In order to ensure that this happens staff will have training on what is considered an incident so that the correct information is recorded and the procedure/guide in the policy for managing behaviours that challenge is implemented. Additionally, all nurses will be instructed to record any changes in residents behaviours, any obvious escalation in behaviours (verbal or physical) on the twice daily report sheet which is provided to the PIC. The PIC will review this to ensure that any obvious behaviours are documented correctly and to ensure that where necessary remedial actions are taken.

Within two days all incident/accident reports will be submitted to the Provider Nominee who will ensure that the procedures have been adhered to. The Clinical Governance team will also support this and will ensure that the procedures have been followed.

The Registered Provider has, in place a Clinical Governance and Operations Manager and a Quality and Risk Manager who are available to offer support and guidance to the Person in Charge.

This system will be reviewed after three months to determine if it is the most effective and efficient manner in which to manage incidents of challenging behaviours reporting.

Proposed Timescale: 31/03/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors reviewed care planning documentation and saw that management and staff did not respond to behaviours that were challenging or posed a risk to the resident or other residents/persons in the designated centre.

6. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
The in house trainer has developed a two day training programme which includes dementia and managing responsive behaviours. This programme is currently being rolled out to all staff and to date 50% of staff have attended the training. It is planned that the remaining staff will have attended the training before end November 2016. Nursing staff have attended care plan documentation training and the PIC will ensure that they have ongoing support and guidance in how best to document residents behaviours and how best to formulate a plan to meet residents care needs. Staff will be instructed to continue to use ABC Charts from which staff and the PIC will be able to identify triggers, consequences and behaviours which they will use to formulate appropriate plans of care. The PIC will ensure that all staff attend training and will maintain the training matrix.

All residents who present with behaviours that challenge care plans will be reviewed to ensure that each care need identified is adequately addressed and an appropriate plan is in place.

Ongoing, the PIC will ensure that through the incident/accident reporting system and the communication systems that all new responsive behaviours, escalation behaviours or changes in the residents behaviours are correctly identified and where necessary care plans are amended or updated to ensure that they are reflective of the residents needs.

As part of the established quality and improvement programme care plans are audited on a regular basis. The PIC has attended auditing training and is proficient in auditing, analysing the findings and creating appropriate action plans to address any identified shortfalls.

Proposed Timescale: Two-day training programme, 50% remaining by 30/11/2016.
Care plan audit – 10/11/2016.
Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Since January 2016 the training records provided to the inspectors identified that 23 staff had participated in the protection of residents from abuse training, however, training has expired for 5 persons working at the designated centre.

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

Please state the actions you have taken or are planning to take:
Currently all staff employed in the centre have up to date recognising and responding to abuse training. As part of the induction programme, staff receive training and guidance on the elderly abuse policy and the PIC will ensure as per company guidelines that all new staff have training within the two-week induction period.

The training matrix has been updated to reflect current training status.

Proposed Timescale: 26/10/2016

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:
The following risks identified by the inspectors had not been assessed and measures and controls put in place to control the risks:

- Maintenance tools (electric drill with a bit inserted and stepladders) were left in a residents' bedroom during periods when the residents were occupying the bedroom.
- Linen trolleys were stored in the corridors blocking handrails.
- Residents' personal and confidential information was not stored securely.
- Cleaning equipment was left unattended/stored in hallways and corridors.
- Training records provided to the inspectors during the inspection identified that a nurse and 4 care staff rostered for duty did not have up-to-date training in moving and handling.
- Residents found it difficult to access seating in the main communal sitting room due to the congestion in the area with mobility aids and furniture.
8. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Immediately, the group Maintenance Manager met with the Maintenance Man on site and has outlined the correct procedures for the safe maintenance and use of equipment’s in resident areas to ensure that residents are not put at risk. This includes, not leaving tools unattended, and if it is not possible to put tools away immediately that the area is locked. Advice notices will be put in place for residents.

Storage space has been created for the linen trolleys so that they can be put away after use and staff have been advised that they should not leave trolleys unattended on corridors when in use.

A lockable cupboard has been provided for resident activity notes and files to be securely locked away. All staff advised not to leave files unattended at any time. The PIC will monitor this on a regular basis.

There is storage space available for staff. Housekeeping staff have been advised that they should not leave cleaning trolleys unattended.

The policies in place are sufficiently detailed to guide staff in the correct procedures and are made available to all staff. Meetings will be planned to discuss health and safety issues and all staff will be advised of the potential consequences and negative outcomes of not following safe practices and procedures.

There has been some reconfiguration of the main sitting room which included downsizing unnecessary furniture. Additionally, seating areas have been created and an underused sitting room/conservatory is now being used more regularly.

The Registered Provider has submitted to the Authority the proposed extension plans and project plan for same.

The risk register will be reviewed and updated to reflect those risks identified and the PIC will undertake a weekly health and safety “walk-about” and will following this review any new risks identified, update the risk register and put in place actions to mitigate or remove the risks.

All staff currently employed in the centre have up to date moving and handling training.

Proposed Timescale: Health & safety meetings to be complete 30/11/2016. Risk register to be reviewed and updated 31/12/2016.
Extension plans – 26/10/2016.
Seating reconfiguration – 26/10/2016.
Proposed Timescale: 31/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents was not in place as inspectors identified during the inspection that medicines were not administered per the prescriber for example the dosage prescribed was not consistently administered.
Management agreed to investigate this serious incident and forward a copy of the investigation and findings to the Authority.

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

Please state the actions you have taken or are planning to take:
There is a robust system in place (since 2011) for investigation and learning from serious incidents. This process does include serious incident review, however on this occasion the error was not identified. The PIC will arrange for a review of the current medication management systems to identify if there are system failures and will develop an action plan to address these to ensure that the system in place for the management of medications is safe and appropriate. Should the PIC identify the need for additional resources the RP will ensure that these are made available.

Since the inspection, all nurses have completed medication management training via HSELand and from the external pharmacist and the PIC has introduced a system of monthly monitoring of all medication charts to ensure that the medication chart, the administration sheet and the medication dispensed from the pharmacy are correct.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Procedures, consistent with the standards for the prevention and control of healthcare associated infections were not fully implemented as a toilet facility was not clean, some sanagenic containers used for the disposal of soiled incontinence products were overflowing or not closed properly and the cleaning schedule had not been kept up-to-date.

The training records identified that 7 staff members had participated in infection-control during the period 2008 until 2012. No staff member has participated in this training since 14 November 2012.
10. **Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
The RP is committed to ensuring that the PIC has the necessary resources and supports required to ensure that infection control practices are safe and in line with best practice. The PIC will nominate an identified staff member with responsibility for monitoring compliance with national standards for infection prevention and control procedures. This person's duties will include regularly auditing and monitoring infection control practices and ensuring that the policies, procedures and guidelines are adhered to. The PIC has undertaken a full review of the current cleaning programme and has identified areas where improvements can be made. She is currently developing a plan which will address these issues. Once complete this will be “rolled out” to staff, commensurate with their work activities and responsibilities.

The in-house trainer has provided up to date infection control training on 7th, 14th and 21st September and to date 75% of staff have attended training. Any staff who have not had the opportunity to attend training, further training dates will be planned. It is planned that all staff will have attended training on/before 15th December.

**Proposed Timescale:** 15/12/2016  
**Theme:**  
Safe care and support  

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The emergency fire signage at a fire exit was cracked.

11. **Action Required:**
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
Emergency fire sign with crack has been replaced. As part of the PIC weekly “walkabout” fire safety will form part of this programme which will include the monitoring of fire signs.

**Proposed Timescale:** 26/10/2016  
**Theme:**  
Safe care and support  

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
Arrangements had not been made for all staff to receive suitable training in fire prevention and emergency procedures as the training records provided to the inspectors on inspection identified that the training had expired on February 2012 and May 2013 for 17 staff members who are rostered on duty. The staff designations include staff nurse and care assistant working night duties, care assistant on day duty, catering, laundry and administration staff.

12. **Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
All staff currently employed in the centre have completed fire safety training. On the day of inspection, the first record provided to the Inspectors was not the most up to date although subsequently the most up to date copy was provided to the Inspectors. To avoid any future confusion, only one overall training record will be maintained in the centre. The PIC will ensure that this is update following any training to ensure that at any given time the training matrix is a contemporaneous record.

**Proposed Timescale:** 26/10/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate precautions against the risk of fire had not been fully implemented as follows:
- Fire doors in high risk areas such as the laundry room, the kitchen, designated smoking room and some residents’ bedroom were held open either with door wedges or furniture.
- Double doors on the corridor leading from the kitchen/dining room towards the designated smoking room did not have hold open magnetic devices attached to the fire alarm system which would close in the event of an emergency. These doors remained open for most of the inspection.

13. **Action Required:**
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The RP has arranged to have automatic magnetic closures to the double doors that lead from the dining/kitchen area to the smoking room.

The kitchen door release has been readjusted so that there is no need to wedge it
All staff have been instructed to ensure that smoking room doors are to be closed at all times and notices have been put in place to remind staff, residents and visitors. Residents have been asked to not wedge bedroom doors open.

The laundry room door has a coded entrance and staff have been reminded that this should be kept closed at all times. Fire safety will be part of the weekly health and safety “walk-about”. Fire safety including the inappropriate opening of doors will be discussed at the health and safety meetings which all staff will be required to attend.

Proposed Timescale: Weekly health and safety walkabout -26/10/2016
Quarterly health and safety meetings next due by 30/11/2016.
Magnetic door closers (kitchen and dining) – 26/10/2016.

**Proposed Timescale:** 30/11/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Adequate precautions against the risk of fire had not been fully implemented as follows:
- A fire exit in the communal sitting room was blocked with sitting room chairs.
- A final fire exit which had a keypad installed close to the door was obstructed by the positioning of a foam fire extinguisher and 4 fire rescue mats which also obstructed the use of the handrail.

**14. 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:**
The sitting room has been reconfigured and unnecessary furniture removed to ensure that the fire exit is not blocked. The issue of fire safety management will be discussed at the planned health and safety staff meetings and moving forward the issues of safety will be added as a regular agenda item to all staff meetings. The foam extinguisher and albac mats have been re-located to ensure that there is no obstruction of the handrail at the fire exit.

**Proposed Timescale:** 26/10/2016

**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 following issues were identified:

- Medicines were administered from a photocopy and or an unsigned pharmacy prescription and the original was not available.
- Medicines were covertly administered.
- It was not possible to reconcile the number of tablets administered as PRN from the blister pack against the recordings in the administration sheet.
- The administration of medicines was outside the prescriber timeframe and the actual time of administering was not recorded.
- Recordings made by the staff nurses administering medicines were difficult to read with regard to comments such as residents refusing medicines.

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

Please state the actions you have taken or are planning to take:
The PIC will arrange for a review of the current medication management systems to identify if there are system failures and will develop an action plan to address these to ensure that the system in place for the management of medications is safe and appropriate. The RP will provide additional resources as identified by the PIC. In the interim period, additional paperwork has been developed to ensure that refusals of medication, changes of times etc. can be recorded.

All nursing staff have completed HSELand training and additional training has been provided by the external pharmacist. The current policy does sufficiently guide staff on best practices on medication management. A copy of this and ABA guidelines on medication management will be provided to all nursing staff.

The PIC has introduced a system of monthly monitoring of all medication charts to ensure that the medication chart, the administration sheet and the medication dispensed from the pharmacy are correct.

Proposed Timescale: 30/11/2016

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:
The pre-assessment information did not take account of all of the information available
and supports that were in place in order to replicate these arrangements to meet the resident’s assessed needs in the designated centre.

The post-admission assessment within the designated centre was not sufficiently comprehensive and did not assess all of the resident’s needs.

16. **Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
The admissions policy will be reviewed and amended if needed to ensure that it guides the PIC and/or any staff involved in the pre and post admission of a resident in how best to ensure that the placement is suitable and can meet the individual needs of the proposed resident, taking into consideration the residents already living within the centre.

The PIC, in accordance with the Health Act, does has the autonomy and the authority to agree that the placement of a resident is suitable or not.

The PIC is satisfied that the liaison person has the necessary skills and is an appropriate healthcare professional to carry out a comprehensive assessment. Following the comprehensive assessment, the PIC will:

(i) carry out a risk assessment to identify if there are any additional concerns, medical illnesses (including responsive behaviours) which may impact on the placement. Where additional resources (including equipment and manpower) are required, these will be identified and agreed with the RP prior to admission;

(ii) review the existing staffing levels using an acuity and ratio based tool and will determine if the existing levels will support a new admission;

(iii) review the current training status of staff to determine whether or not additional support and/or training is required to support the placement.

The PIC will ensure that the care plan is prepared within 48 hours of admission. Where a resident is admitted with a current or past history of responsive behaviours a record will be kept which will allow staff to identify presenting behaviours, potential triggers, the consequence of behaviours and which interactions the resident responds better to. Once this information is available, the care plan can be developed. With the residents’ agreement, input will be sought from them and their family. The PIC will ensure that for all new admissions that the care plan will be reviewed and updated on a weekly basis for the first month to ensure that it adequately guides staff. It clearly identifies residents’ needs and guides staff in how best to meet these needs.

The PIC will continue to monitor this “settling-in” phase and will discuss with the RP if any other resources are required and will ensure that where necessary all referrals to
medical/allied health professionals are made in a timely fashion.

The PIC will arrange for a review of the current medication management systems to identify if there are system failures and will develop an action plan to address these to ensure that the system in place for the management of medications is safe and appropriate.

With regard to any of the measures outlines above, where the PIC identified a requirement for additional resources the RP is committed to working with the PIC to ensure that these resources are made available.

Pre admission risk assessment – 26/10/2016.

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<th>Proposed Timescale: 30/11/2016</th>
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<tr>
<td>Theme:</td>
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<tr>
<td>Effective care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care and treatment plans were not drawn up in an individual care plan that reflected the resident’s needs, interests and capacities.

**17. 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:**
The PIC is satisfied that she has the necessary knowledge and skills to be able to determine the quality of the care plans to ensure that they adequately reflect the current status of residents, residents care needs and to be able to determine the plans of care adequately address residents’ needs.

The PIC has arranged update training for all staff nurses which included their accountabilities and responsibilities in terms of documentation and in future where needs are identified she will arrange further for nurses to have additional training in care planning. The PIC will on an ongoing basis provide support and guidance to nurses in how best to develop and maintain care plans.

There is already a care plan auditing system in place whereby a percentage of care plans are audited monthly. The PIC will ensure through this auditing system that the residents care needs are reflected in the plans of care and they sufficiently guide staff to meet the residents care needs.
The PIC will ensure that each residents care plan is reviewed and adequately reflects the needs of residents. All staff currently have access to the care plans and are actively encouraged to use these in their daily practice.

Care plan audit – 10/11/2016.
Full care plan review to be complete by 31/01/2017.

**Proposed Timescale:** 31/01/2017

**Theme:** Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Appropriate medical and Allied health care, (appropriate referrals had not been made to a resident's GP and Allied health professionals to review a resident's care) including a high standard of evidence-based nursing care in accordance with professional guidelines was not provided to a resident.

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

**Please state the actions you have taken or are planning to take:**
On this occasion while referrals were made to the appropriate allied health professionals which involved the GP, mental health team, the recording of these was not done in a manner which allowed each of retrieval of information.

As part of the care planning training the nursing care document was included and this document does include a recording sheet for all referrals. To ensure that information is recorded appropriately in the future the PIC will ensure that diaries and medical notes are used as part of the auditing system.

**Proposed Timescale:** 30/11/2016

**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:**
A copy of the proposed improvements (alterations and an extension to the existing nursing home to include additional bedrooms, communal space, storage and bathroom facilities) to be made to the premises which included notification by the planning department of the decision to grant permission for these works which was received subject to conditions on 27 June 2016 should be forwarded to the Authority.

Flooring was stained at the toilet base in a shower room and the floor covering is ill fitting up the wall.

19. **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:**
The Registered Provider has submitted to the Authority the proposed extension plans and project plan for same.

The flooring in the shower room has been replaced.

**Proposed Timescale:** 26/10/2016

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**Outcome 14: End of Life Care**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
An end of life care plan was not in place for all residents.

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

**Please state the actions you have taken or are planning to take:**
Of the current residents 78% have engaged in the discussion with regards to their End of Life Care. Of the remaining residents, they and/or their families have been offered the opportunity to discuss their end of life care. Some care currently considering this, others do not wish to engage in the process. The care plans have been updated to reflect this.

We also offer each resident the opportunity to complete their end of life wishes using the documentation based on the Irish Hospice Foundation.
Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All residents did not have opportunities to participate in activities in accordance with their interests and capacities.

21. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The activities programme has been reviewed to ensure that all residents can participate in activities in accordance with their interests and capacities. Since the inspection, care staff are now taking a more active role in the activities programme and therefore there are increased opportunities for residents to be involved.

Currently, each resident has a completed activity assessment (functional, behavioural, likes/dislikes etc.). The PIC and the Activities Coordinator will review these to determine if there are other interests and hobbies that residents have can be incorporated into the current activities programme.

The PIC will ensure that the Quis tool is used on a regular basis to determine if the interactions between staff and residents are used as an opportunity to provide meaningful conversation. If the results show that improvement can be made, the necessary training will be provided.

Proposed Timescale: 31/01/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of staff was not appropriate having regard to the needs of the residents.

22. 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:
Staffing levels are reviewed using an acuity and ratio tools as recommended to ensure validity of the findings on a fortnightly basis. Moving forward the PIC will ensure that staffing levels are reviewed before any new resident is admitted and within three days of the actual admission to ensure that the staffing levels are adequate.

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<td><strong>Theme:</strong></td>
<td><strong>Workforce</strong></td>
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<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Staff did not have access to appropriate training.</td>
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<td><strong>23. Action Required:</strong></td>
<td>Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.</td>
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<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.</td>
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<td>Please state the actions you have taken or are planning to take:</td>
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<tr>
<td></td>
<td>The training needs identified throughout the body of this report have all been addressed.</td>
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<td>Infection control – 75% staff completed infection control training, remaining staff to be trained before end November.</td>
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<td></td>
<td>All staff have attended moving and handling training. All staff have attended abuse awareness and recognition training. 50% have attended behaviour that challenges. The remainder to attend before end November.</td>
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<td>All staff nurses have attended care plan training and medication management training.</td>
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<td>The training needs analysis for the centre will be complete by end of January 2017 thereafter the training programme for the centre will be developed and the “roll out” will commence March 2017.</td>
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<td>The PIC will ensure that the contemporaneous training matrix will be maintained in the centre.</td>
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<td><strong>Theme:</strong></td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised.

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

**Please state the actions you have taken or are planning to take:**
Currently the centre has employed a PIC, DON and ADON who all have the authority to supervise and monitor staff. The Chef will oversee and monitor the catering staff. On a day to day basis and during each shift the nurse on duty will guide, monitor and supervise care staff.

Moving forward when planning off duties, unless there are unforeseen absences or sicknesses the PIC will, where possible, that newly qualified staff are supported by more senior staff and will discuss any issues identified with putting this into practice with the RP to see if alternative plans can be made.

There is an on-call system which is available to staff out of hours to guide and support where necessary. There are protocols available within the centre that guide staff in the actions they should take in an unforeseen or emergency situation. As part of the induction programme all staff will be made aware of these and all nurses will receive ongoing support from the PIC in relation to how they might guide staff and supervise junior staff during the course of their duties.

**Proposed Timescale:** 26/10/2016