Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	St Ursula's Nursing Home
Centre ID:	OSV-0000171
Centre address:	Golf Links Road, Bettystown, Meath.
Telephone number:	041 982 7422
Email address:	seamus.sarsfield@saintursulas.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Ballyhavil Limited
Provider Nominee:	Seamus Sarsfield
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	0

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
19 August 2016 08:45	19 August 2016 20:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Non Compliant - Moderate	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Non Compliant - Moderate	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. The inspection also considered notifications and other relevant information. Inspectors also followed-up on progress with completion of the action plan from the last inspection of the centre in September 2014. There were 21 actions identified from non-compliances found on the last inspection. Inspectors' findings on this inspection confirmed satisfactory completion of 14 actions, with the remaining seven actions progressed but not completed. Partially completed actions are restated in the action plan for this inspection.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Health Information and Quality Authority (HIQA). In addition, evidence-based guidance was developed to guide the providers on best

practice in dementia care and the inspection process. Prior to the inspection, the provider completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Residents' accommodation in the centre was provided over two floors. The centre did not have a dementia care unit and residents with dementia integrated with the other residents in the centre. Residents who were assessed as independently mobile were accommodated on the first floor, with a stair-lift provided. The provider discussed plans to refurbish the centre in order to provide all residents' accommodation on the ground floor. The design and layout of the centre generally met its stated purpose and provided a comfortable and therapeutic environment for residents with dementia. Inspectors found the provider, person in charge and staff team were committed to providing a quality service for residents with dementia. This commitment was demonstrated in the work they had done to provide a comfortable and therapeutic environment for residents with dementia living in the centre.

Inspectors met with residents and staff members during the inspection. They tracked the journey of four residents with dementia within the service. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined the relevant policies including those submitted prior to inspection.

There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or are informed of any abuse taking place. There were also policies and practices in place around managing responsive and psychological behaviours of dementia. Improvements were required in use of restraint, including environmental restrictions to ensure its use reflected national restraint policy guidelines. Residents were safeguarded by staff completing risk assessments and reviewing their needs in relation to the plans of care that were in place to support and optimize their health and wellbeing. The provision of residents' activities also required improvement to ensure that the interests and capabilities of residents with dementia informed how their activity needs were met. Medicines management procedures were not in line with legislative and professional requirements. Inspectors found a review of staffing resources was required to ensure staffing levels and skills were appropriate to meet residents' needs.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

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:
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

There were 24 residents in the centre on the day of this inspection; 10 residents had assessed maximum dependency needs, six had high dependency needs, five residents had medium dependency needs and three residents had assessed low dependency needs. Eight residents had a formal diagnosis of dementia and a further four residents had symptoms of dementia.

There were suitable arrangements in place to meet the health and nursing needs of residents with dementia. A comprehensive assessment was carried out and care plans were developed based on assessments of need and in line with residents' changing needs. Documentation required improvement to reference residents' and their families' involvement in the care planning process: with the exception of end-of-life care planning which recorded the wishes of residents, including residents with dementia. Systems were in place to prevent unnecessary hospital admissions. The nutritional and hydration needs of residents with dementia were met and residents were protected by safe medicine policies and procedures.

Residents had a choice of general practitioner (GP). Documentation and residents spoken with confirmed timely access to GP care. Many residents from the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Residents also had good access to allied healthcare professionals including physiotherapy by a physiotherapist employed by the provider. Dietetic, speech and language therapy, dental, ophthalmology and podiatry services were available to residents. However, residents did not have timely access to occupational therapy (OT) services and this had a negative impact on some residents with dementia. A resident with dementia requiring postural support was referred by hospital OT services for priority seating assessment by community OT services in February 2016. This

assessment had not been completed and inspectors found that the seating available did not meet the needs of some residents with dementia. This finding is discussed and actioned under outcome 6 of this report. There was evidence that residents' positive health and wellbeing were promoted with regular physiotherapy optimizing their safe mobility and an annual influenza vaccination programme. Residents in the centre had access to mental health of later life services and palliative care services.

Inspectors focused on the experience of residents with dementia on this inspection. They tracked the journey of four residents with dementia and also reviewed specific aspects of care such as nutrition, social care and end-of-life care in relation to other residents.

There were systems in place to optimize communications between the resident, families, the acute hospital and the centre. The person in charge or senior nurse visited prospective residents in hospital, or their home in the community, prior to admission. Prospective residents and their families were also welcomed into the centre to view the facilities and discuss the service provided before making a decision to live in the centre. This gave the resident and their family information about the centre and also ensured them the service could adequately meet their needs.

A copy of the Common Summary Assessments which details the assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme was not routinely received by the centre but was available on request. Residents' files held their hospital discharge documentation on their admission to the centre including a medical summary letter, multidisciplinary assessment details and a nursing assessment. Inspectors also examined the files of residents who were transferred to hospital from the centre and found that a detailed a summary of their health and medications was referenced. A 'communication passport' document had been developed for residents with communication needs that detailed their preferences, dislikes and strategies to prevent or to support their behavioural and psychological symptoms of dementia. The procedure in practice was that a copy of this document accompanied each resident with dementia to support their communication needs while accessing services outside the centre. However, this arrangement was not documented in the communication policy in the centre. Where possible, the centre put arrangements in place where residents were escorted by a member of staff to attend out-patient appointments. On the day of this inspection, inspectors observed that a staff member accompanied a resident to an out-patient appointment.

Residents had a comprehensive nursing assessment completed within 48 hours of admission to the centre. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, their level of cognitive health and skin integrity among others. A care plan was developed to inform each resident's care needs. Care plans had improved since the last inspection in September 2014 and were found to be person-centred and to contain appropriate information on care interventions to direct staff in meeting residents' needs. However, some improvements were required to ensure documentation of residents' needs was clearly stated. Care plans were updated routinely on a three to four-monthly basis or to reflect residents' changing care needs. Some improvement was also observed to be required in the content of daily progress notes to ensure they were more comprehensively linked to care plans. While

the person in charge confirmed that residents and their families were involved in care plan development and in reviews thereafter, this process was not recorded to detail those consulted and any changes made. A pain assessment tool for residents who were non-verbal was available. While there was a record of residents' past interests and evidence that they were supported to continue to enjoy these interests in the centre where possible, there was limited evidence of a comprehensive assessment of activation needs in the nursing home environment for some residents with dementia who were no longer able to enjoy group-based activities or pursue past interests. This finding is discussed in detail and actioned in outcome 3.

Staff provided end-of-life care to residents with the support of their medical practitioner and community palliative care services. Palliative care services were not supporting any residents on the day of this inspection. Inspectors reviewed end-of-life care plans and found that they outlined the physical, psychological and spiritual needs of the residents, including wishes regarding the place for receipt of care. The centre did not provide an oratory but residents were facilitated to practice their religion and had access to clergy of different faith denominations. Staff outlined how religious and cultural practices were facilitated within the centre, including a weekly mass. All residents in the centre were accommodated in single rooms. While a designated room was not provided for relatives, they were facilitated to be with their resident during end-of-life care and were provided with refreshments. Staff were trained to administer subcutaneous fluids to treat dehydration to avoid unnecessary hospital admission.

There were no incidents of pressure-related skin ulcers since 01 January 2015. There was one resident receiving wound care. Comprehensive wound monitoring procedures were put in place since the last inspection in September 2014 which included photographs of wounds. Residents at risk of developing pressure related skin ulcers had risk assessments completed with care plans in place for residents identified as being at increased risk to prevent occurrence. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate the risk of pressure ulcers developing. There were no residents with 'grade two' pressure ulcers at the time of this inspection.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were closely monitored and checked routinely on a monthly basis or more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. Although no evidence was found of dehydration, fluid balance charting was not used to ensure that residents with specified minimum levels of fluid intake had their needs achieved. Inspectors saw that a choice of hot meal was offered. There were arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on diabetic and fortified diets, and also residents who required modified consistency diets and thickened fluids, received the correct diets. Residents dined in the dining room. The dining room did not provide adequate space for all residents to dine together. An arrangement was in place where meals were provided in two sittings in the dining room and also at a table in the sitting room used mainly by residents with assistive wheelchairs and in need of assistance with eating. The lunchtime meal in the dining

room was a social occasion. However, improvement was required to ensure the lunchtime meal was provided to residents at the time specified. Inspectors observed that the lunchtime meal due to be served at midday was served at 13:00hrs which resulted in many residents waiting for their meal. The menu was undergoing change, with the input of the dietician and a process of offering sample meals was taking place to ascertain what dishes residents liked best. Alternatives were available and residents complimented the food they received. Staff sat with residents and provided encouragement or assistance to them with their meal.

There were arrangements in place to review accidents and incidents within the centre, and residents were assessed on admission and regularly thereafter for risk of falls. The centre's physiotherapist was involved in developing assessment and treatment plans for residents who fell or were at increased risk of falling. Care plans were in place and following a fall, the risk assessments were revised, medicines reviewed and care plans were updated to include interventions to mitigate risk of further falls. There was evidence of learning identified from investigations of falls and this was implemented in practice. Monthly resident fall audits reviewed by inspectors demonstrated a significant reduction in the number of falls in the centre.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented for the residents who were case tracked. Inspectors found that some practices in relation to prescribing and management of out-of-date medicines required improvement to ensure they met with regulatory requirements. Since the last inspection, times on the prescription and administration records were changed to ensure that medicines were administered as prescribed. An inspector attended a medication round and administration practice was found to reflect professional guidelines. While procedures for removal of out-of-date medicines were included in medicine policy documentation, inspectors found that this area required improvement as some out-of-date medicines were present in the medicine storage trolley. Controlled medicines and refrigerated medicines were managed appropriately. Prescription of medicines administered in 'crushed' format and p.r.n. medicines (a medicine only taken as the need arises) were not prescribed in line with prescribing legislation and as such posed a risk of medication error. In addition, the maximum dosage of p.r.n. medicine to be administered over a 24-hour period was not stated. Policy documentation was available to inform management of any medicines errors. There were no medicines errors recorded in the centre. Residents had access to a pharmacist and the pharmacist was facilitated to meet their obligations.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:
Inspectors found that appropriate measures were in place to safeguard and protect residents from being harmed or suffering abuse. Staff understood and implemented the policy in place on identifying and responding to elder abuse.

A number of staff had received training on identifying and responding to elder abuse and further training was planned. The policy in place reflected the national policy on safeguarding vulnerable persons at risk of abuse. The person in charge and staff spoken with demonstrated sufficient knowledge of the different forms of elder abuse and their responsibility to report and reporting procedures. Inspectors saw evidence where a suspicion of abuse by a person or persons external to the centre reported to the person in charge was appropriately investigated and residents were safeguarded.

Some residents had behavioural and psychological symptoms of dementia (BPSD). Inspectors saw that assessments had been completed and used to inform positive support care plans, which were reviewed on an ongoing basis. However, inspectors found that while the care plans in place clearly identified triggers to BPSD, strategies and techniques to de-escalate responsive behaviours were generic and not person-centred. There were no incidents of BPSD observed on this inspection indicating that residents with dementia were well supported. Staff spoken with discussed appropriate interventions they used to prevent and support individual resident's responsive behaviours. Inspectors also observed that staff approached residents with behavioural and psychological signs of dementia in a sensitive and compassionate manner and the residents responded positively to the techniques they used. There was evidence of interdisciplinary collaboration and person-centred approaches with positive outcomes for residents who had responsive behaviours.

Inspectors reviewed the use of restraint in the centre. Eight residents were documented as using bedrails and one resident used a lap belt, which was attached as part of their assistive chair. Inspectors observed that some of these residents used partial-length bedrails as enablers to support their feelings of security. However, bedrail risk assessments and related documentation, including alternatives trialled prior to use of bedrails, required improvement to reflect national restraint policy guidelines. Additional equipment such as a small number of low beds and sensor alarms were available, but there was insufficient evidence to support that they were trialled as a less-restrictive alternative. The door to exit the centre was controlled by a thumbprint-sensor and could not be operated by residents without the assistance of staff. Residents accommodated on the first floor could not access their accommodation from the ground floor as they wished and as appropriate without the assistance of staff as it was locked by an electronic fob. These locks were not recognised as devices restricting residents' freedom. However, the provider and person in charge advised inspectors at the inspection feedback meeting that while they were in use to protect residents from risk of injury from the stairs to the first floor and from the busy road and traffic in front of the centre, their use would be reviewed.

There was a system in place to manage residents' finances and property securely and transparently. Inspectors observed that residents could choose to securely store their

valuables in their room if they wished as they were provided with a lockable safe. Inspectors viewed records of residents' money kept in safekeeping for them and found them to be well maintained. All transactions were co-signed by two members of staff. Inspectors checked a sample of residents' finances and found their balances to be accurate and in line with the records maintained. Residents had access to their money as they wished.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

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:
Residents with dementia were consulted with and supported to participate in the organisation of the centre. Overall, residents' privacy and dignity was generally respected. However, closed circuit television (CCTV) cameras were in operation in communal sitting areas and the dining room where a reasonable level of privacy for residents would be expected. Residents were supported to make choices about their day-to-day lives. While there was opportunity for most residents with dementia to participate in activities that suited their interests and capabilities, this was not based on a comprehensive assessment of activation needs. The needs of residents with advanced dementia were not adequately met to reflect their interests and capabilities.

Addressing the social care needs of residents was integral to the role of healthcare assistants however; inspectors observed that activities were regularly interrupted to provide resident care. There was no person responsible for co-ordinating resident activities to meet the interests and capabilities of residents, including residents with dementia. Although there was evidence in residents' documentation records and on the day of inspection of residents enjoying activities provided, this was not the finding for all residents with dementia. Inspectors observed that a number of residents slept through the activities and did not participate. In addition, a schedule of activities was not clearly displayed so residents could make a choice regarding their wish to attend the activity scheduled. Inspectors' findings indicated that significantly improved assessment for residents with dementia was required to ensure that activities provided met the interests and capabilities of residents with dementia including whether 1:1 or small group activities were most appropriate to meet their needs. While a member of staff had completed accredited training in sensory-based activity provision suitable for residents with dementia, a robust sensory focused activity programme was not available for residents with dementia. Although the number of residents with severe dementia was

small, approximately 50% of residents had a formal diagnosis of dementia or had symptoms indicative of onset of dementia. This finding was discussed at feedback of inspection findings with the provider and person in charge.

Residents with dementia had access to independent advocacy services. While resident meetings were occurring, minutes of these meetings required documenting which the person in charge advised inspectors was in process. However, there was evidence of improvements made based on suggestions by and in consultation with residents, such as the application of differing contact transfers to residents' bedroom doors which assisted orientation of residents with dementia and review of lunch menus. The provider and staff demonstrated resourcefulness and imaginative creativity with work carried out to make the centre comfortable for residents with dementia through art work, homely furnishings and the use of old familiar memorabilia.

Residents were facilitated to exercise their civil, political and religious rights. Staff sought the permission of residents with dementia in the centre before undertaking any care tasks and they were consulted about how they wished to spend their day and about care issues. Residents spoken with expressed their satisfaction at opportunities provided for them to practice their religious faiths and choices afforded to them in their day-to-day lives. Arrangements were also in place to ensure residents had opportunity to exercise their right to vote. Wheelchair accessible transport was put in place with a staff escort for one resident to travel to Knock. Residents' wishes were prioritized when planning excursion venues. Residents' wishes and preferences also informed their daily routine regarding the times they retired to bed and got up in the morning. There were no restrictions on visitors and residents could meet visitors in private in a small conservatory in the centre. Inspectors observed residents' visitors visiting them throughout the day of inspection. Residents accommodated on the first floor could not access their accommodation without the assistance of staff to open an electronic fob lock.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record the quality of interactions between staff and residents at five minute intervals in the sitting room and the dining room area. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the effect of the interactions on the majority of residents. Inspectors' observations on this inspection concluded that while there was good evidence of positive connective care with individual residents, the experience for some residents with severe dementia was task-orientated or reflected neutral care. However, task-orientated interactions were generally of a good quality and referenced episodes of care provision. The observations of neutral care interactions were only observed for residents with severe dementia who were not facilitated to participate in or experience staff interaction through suitable activation during the 30 minute observation periods.

Inspectors saw that staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. All residents were accommodated in single bedrooms. Staff were observed knocking on bedroom and toilet or bathroom doors. Privacy locks were in place on all bathroom and toilet doors. Bedroom and toilet

and bathroom doors were closed during all personal care activities. Inspectors observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff and residents knew each other well.

Residents had a section in their care plan that covered communication needs, and there was a communication policy in place. However, the communication policy did not reference communication needs of residents with dementia and strategies to effectively meet their communication needs.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The centre had a policy and procedure in place for the management of complaints, including details of the appeals process. However, improvement was required in the complaints policy details and in complaint record keeping.

A summary of the complaints procedure was displayed at the entrance of the centre, and was also included in the Residents' Guide. While there was a person nominated to deal with complaints, the policy did not contain details of the person nominated to ensure that all complaints were appropriately responded to and that the required records were maintained.

A complaints log was maintained in the centre, which was made available to inspectors on the day of the inspection. There was evidence of complaints being recorded, including the details of complaints and the action taken. While the person in charge confirmed that complainants expressed their satisfaction with the outcome of complaints, this information was not consistently recorded.

A review of concerns and complaints was carried out every quarter as part of the governance and management report for the centre.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors' findings indicated that appropriate staff numbers and skill levels required review to ensure they adequately reflected the assessed needs of residents including residents with dementia. Improvement was also required to ensure that mandatory training was facilitated in place for all staff, and that all volunteers are recruited, selected and vetted in accordance with best recruitment practice.

An action plan from the last inspection in September 2014 referenced findings where all staff members had not received formal annual appraisals or regular formal supervision. Inspectors found on this inspection that staff appraisals were in place. The person in charge provided evidence of staff appraisals conducted in 2016. However, while the person in charge had used these appraisals to identify staff training needs, appraisals required further improvement to inform ongoing professional development opportunities for staff. Supervision of staff was recently strengthened by the appointment of an additional layer of clinical management. However, inspectors observed that there were insufficient staff to meet the activation needs of residents with dementia.

The number of staff working in the kitchen also required review on the last inspection. Catering staff levels had since been revised to ensure there were sufficient staff in place, particularly at mealtimes.

There was an actual and planned staff rota in place, which reflected the staff numbers on duty on the day of the inspection.

A training programme was in place to support staff to provide care that reflected up-to-date, evidence-based practice. A number of nursing and care staff had attended training on dementia care and management of behaviours and psychological symptoms of dementia in the last year. Although inspectors did not observe any incidents of unsafe moving and handling of residents, not all staff had received mandatory training in moving and handling practices. While all staff spoken with by inspectors were knowledgeable regarding protection of residents, the training records did not confirm that all staff had attended training in the prevention, detection and management of abuse. The person in charge committed to ensuring that these staff would complete up-to-date training in the prevention, detection and management of abuse in the coming weeks.

Inspectors examined staff files which were found to contain all of the information required by Schedule 2 of the regulations.

There was evidence that regular staff meetings were held for staff at various levels, with actions from these meetings clearly indicated.

While a number of volunteers attended the centre on a regular basis, not all of these people had completed Garda Vetting in their employment files or had their roles and responsibilities set out in writing.

Judgment:
Non Compliant - Major

Outcome 06: Safe and Suitable Premises

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:
For the most part, the premises was found to meet the needs of all residents and the design and layout generally promoted the dignity, independence and wellbeing of residents with dementia. A number of improvements were required in relation to smoking facilities, freedom of movement of residents between floors, the external garden area and repair to fabric on some assistive seating equipment.

St Ursula's accommodated 24 residents over two floors, all in single bedrooms. Seven bedrooms were located on the first floor. 22 bedrooms had wash hand basins and two bedrooms had an en-suite toilets and wash basins. One of these en-suite facilities also had a shower fitted. Most bedrooms were personalized with residents' possessions and some also had sensory decorations. Each bedroom also had a television and adequate storage facilities. Bedroom doors had been covered in transfers that resembled domestic front doors. Each door was different and fitted in consultation with residents. Signage and red coloured indicators in floor covering supported residents to locate toilets and communal rooms. Residents had access to the first floor via a stair-lift. Inspectors were advised and saw that residents who could mobilise independently, as confirmed by assessment, were accommodated on the first floor. However, electronic locks were in place at entrances to the stairway and stair-lift to the first floor which restricted residents moving independently between their bedrooms on the first floor and the communal rooms on the ground floor. This finding is discussed and actioned in outcome 3.

There was a secure external garden area provided for residents' use. Other areas available for use by residents included a small conservatory, a dining room and a large sitting room. These rooms were clean and suitably decorated with comfortable furnishings, fixtures and fittings. They were decorated in a traditional domestic style with old familiar memorabilia at various points. A smoking room was accessible via the sitting room. During the last inspection, inspectors identified that passive cigarette smoke was not sufficiently contained in the designated smoking room as a smoke odour was present in the adjacent sitting room. While the provider had installed an improved ventilation system and supported one resident to use electronic cigarettes to address

this issue, inspectors found on this inspection that odour of smoke was still detected in the sitting room and adjoining corridor.

The centre fabric was clean, brightly painted and well-maintained. A large assisted bathroom was located on the first floor, and two assisted shower rooms and a toilet were available for residents on the ground floor. Grab rails were appropriately provided in bath, toilet and shower areas, and some of the toilet seats were of a contrasting colour to support residents with dementia. The placement of sinks, hand dryers and hand towel dispensers required review to improve ease of access for all residents, particularly those using wheelchairs.

Handrails were fitted on both sides of the corridors and were in a contrasting colour to walls to support independent movement of residents. Call bells were in place in bedrooms, toilets and bathrooms. Assistive equipment was available to residents that required support, which were found to be stored in designated areas when not in use. However, the fabric on a number of pieces of assistive equipment which were in use by residents was found to be in need of repair.

A sluice room was available in the centre, with access restricted for unauthorized persons. A bed-pan washer was available in the sluice room, as was a dedicated hand wash basin. Appropriate laundry facilities were in operation in the centre.

Since the last inspection the provider had reviewed the layout of a number of residents' bedrooms to ensure that their dimensions were in compliance with the regulations and met the needs of residents.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	St Ursula's Nursing Home
Centre ID:	OSV-0000171
Date of inspection:	19/08/2016
Date of response:	16/09/2016

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Medications administered on a p.r.n. (as required) basis were not prescribed in line with prescribing legislation and as such posed a risk of error.

The maximum dosage of p.r.n. medication to be administered over a 24 hour period was not stated.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
To Comply under Regulation 04(1) As part of the comprehensive multidisciplinary review of our medication management, the policy has been reviewed to ensure that current regulatory guidelines and best practice are fully complied with. The multidisciplinary policy review will be completed by the end of September with training sessions for staff nurses arranged for 21th September by the pharmacists. New kardex and MAR sheets have been implemented with a clear layout to be introduced by the 19th of September; this will cover all administration of medication daily, with daily reviewed by pharmacists as part of this process.
A copy of the revised kardex for one of the current residents has been attached.

Proposed Timescale: 10/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While the person in charge confirmed that residents and their families were involved in care plan development and in review of care plans, this process was not recorded to detail the consultation process including those consulted and changes made.

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

Please state the actions you have taken or are planning to take:
To comply under Regulation 05(4) Our residents care plans are developed based on the resident's assessments and changing needs at each given aspect of their life. Our residents and families are very much involved in this every 3 to 4 months. However our documentation did not reflect this. We have introduced a resident/Family discussion sheet which will highlight all discussions and changes at our meetings.

Proposed Timescale: 28/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans required improvement to ensure that residents' needs were clearly stated.

There was limited evidence of comprehensive assessment of residents' activation needs

Some improvement was required in the content of daily progress notes to ensure they were comprehensively linked to care plans.

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

Please state the actions you have taken or are planning to take:
To comply under Regulation 05(2,3); We will be reviewing our Care Plan of our residents and incorporating a resident/family discussion sheet to ensure that they are comprehensively linked to our residents health , personal and social care needs. All care planning will be complete within 48 hours of admission.

Proposed Timescale: 07/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Medications administered in 'crushed' format which was in a format not prescribed.

4. 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:
To Comply under Regulation 06(1) A multidisciplinary review of the medication policy and procedures, and crushing guidelines have been reviewed from the revised medication policy. Mars sheets to be implemented by Tuesday 20th Sept and new Kardexs implemented by mid October 2016

Proposed Timescale: 10/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents did not have adequate access to occupational therapy to support their needs.

5. Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

Please state the actions you have taken or are planning to take:
To comply under Regulation 06(2) (c) due to circumstances beyond our control we have had to employ a private occupational therapist to assess all of our residents for seating, postural support. She is due to visit on the 12th Sept 2016.

Proposed Timescale: 29/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure the lunchtime meal was provided to residents at the time specified

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

Please state the actions you have taken or are planning to take:
To comply under Regulation 18(2) Meals are provided at regular times throughout the day. Mealtimes are displayed on the menu board and all residents informed by staff daily. The PIC will ensure that all mealtimes correspond with the times displayed daily. Regular refreshments and snacks are available at any time at the residents request.

Proposed Timescale: 16/09/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some out-of-date medications were present in the medication storage trolley.

7. Action Required:
Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

Please state the actions you have taken or are planning to take:
A comprehensive review of the medication policies and procedures, the layout of the trolley has been reviewed. Each resident will have a discreet area for the storage of their non solid oral dose medication. By isolating all medication for each resident discreetly, any duplicate will be highlighted and minimised. A small sharps bin has been included in the drugs trolley. This ensures that as soon as a medicine needs to be disposed of, this can be done immediately. The HSE dump campaign notice has been fixed to the wall beside the yellow sharps bins to ensure that all medication is disposed of correctly
In addition, the external auditing conducted by the pharmacist will focus on storage and there will be unannounced audits to ensure that it is maintained compliantly at all times

Proposed Timescale: 10/10/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Bedrail risk assessment and assessment of need documentation including alternatives trialled to inform decisions to use bedrails required improvement to reflect national restraint policy guidelines.

An internal door with a coded lock to the first floor and a lock on the door to exit the centre were not recognised as devices restricting residents' freedom.

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

Please state the actions you have taken or are planning to take:
To Comply under Regulation 07(3) We are currently reviewing our restraint policy and procedures in line with national policy. We will be implementing as much as reasonably practicably possible a restraint free environment. St Ursula's Nursing Home is continuously updating our restraint assessment on all residents.
The door leading to and from the upstairs bedrooms will be reviewed in line with our risk assessment policy and our restraints policy.
We are also reviewing our front door policy.

Proposed Timescale: 20/11/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Positive support care plans in place clearly identified triggers to residents' behavioural and psychological signs of dementia; however, strategies and techniques to de-escalate behaviours were generic and not person-centred.

9. 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:
We are reviewing the Care Plans of our residents that display behavioural and psychological symptoms of dementia (BPSD). From this we will be implementing an A. B. C approach. This will Identify possible triggers incorporating the P.I.E.C.E framework. All staff will be trained with the knowledge and skills appropriate to manage behaviours that are challenging.

Proposed Timescale: 30/10/2016

Outcome 03: 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:
The communication policy did not reference communication needs of residents with dementia and strategies to effectively meet their communication needs.

10. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
To comply under Regulation 04(1) Our current communication policy is now under review which will include dementia specific communication needs. With the introduction of an improved communication passport for all our residents and adapting our communication picture book.

Proposed Timescale: 10/10/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Residents accommodated on the first floor could not access their accommodation without the assistance of staff to open an electronic lock.

11. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
To comply under the regulations 09(3) (a) we are in the process of reviewing our full risk assessment of all residents residing upstairs along with any new residents. As regards access keys to upstairs one will be provided for any resident who wishes to have one.

Proposed Timescale: 30/10/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Closed circuit television (CCTV) cameras were in operation in communal sitting areas and the dining room where a reasonable level of privacy for residents would be expected.

12. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
To Comply under regulations 09(3) (b) We at St Ursula's have disconnected our CCTV in communal areas following HIQA Inspection.

Proposed Timescale: 16/09/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there was opportunity for most residents with dementia to participate in activities that suited their interests and capabilities, this was not based on a comprehensive assessment of activation needs.

13. 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:
To Comply under Regulations 09(2) (b), A daily activity schedule has been implemented. A notice board and visual pictures are in full view for everyone in the main corridor. At present we have a temporary person employed for uninterrupted time with our residents along with group activities daily Two other staff have had a one day course in Dementia specific activities. Two more are attending training on the 28th September 2016 .

We are also implementing patient specific activities for each resident that will address the residents sensory stimulation along with memory activities whereby developing memory boards for each residents to be placed in their room.

Proposed Timescale: 10/10/2016

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints policy did not contain details of the person nominated to ensure that all complaints were appropriately responded to and that the required records were maintained.

14. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
To comply under Regulation 34(3) The nominated person has been updated and documented in the
Current complaints policy.

Proposed Timescale: 16/09/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure that records of complaints are maintained and include the outcome of the complaint and whether or not the complainant was satisfied.

15. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
To comply under Regulation 34(1) (f) Full review of Complaints policy and procedure has been reviewed. Full information has been given to staff of the relevant persons to be informed of, if any issues concerning the establishment are made. Detailed documentation is provided and to be filled out so to address such issues in a timely manner with full detail of investigation, outcome of complaint will be recorded and whether or not the person is satisfied.

Proposed Timescale: 30/10/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staff numbers in the centre on the day of the inspection did not meet the assessed needs of the residents.

16. 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:
To Comply under regulation 15(1) We are currently recruiting for two part-time carers in addition to an activity coordinator and physiotherapists.

Proposed Timescale: 30/10/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received mandatory training in moving and handling practices and in the prevention, detection and management of abuse.

17. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
To comply under Regulation 16(1) (a) Any deficit of staff mandatory training needs will be addressed. Staff to obtain appropriate training required.

Proposed Timescale: 30/10/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All volunteers must be Garda vetted in line with the Regulations

18. Action Required:
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
To comply under Regulation 30(c) Garda Vetting is in progress for any additional services that attend St Ursula's Nursing Home regardless of private or voluntary input so to comply with the regulatory requirements.

Proposed Timescale: 06/12/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of all volunteers were not set out in writing as required by the Regulations

19. Action Required:
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
To comply under Regulation 30(a) All Job Roles and Job descriptions for all staff will be addressed.

Proposed Timescale: 06/12/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Review was required to ensure residents could access their accommodation on the first floor independently as appropriate.

The fabric on some assistive chair was worn and torn.

Ventilation arrangements in the smoking room were not adequate to ensure no smoke leaked in the adjoining sitting-room.

20. 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:
To Comply under Regulation 17(2)-
1. All Residents have access to an external garden at all times.
2. Inside Smoking room has been closed alternate accommodation has been provided.
3. Assessment of all residents' chairs will be undertaken from Monday 12th Sept and any issues with same will be addressed.

Proposed Timescale: 04/01/2017