

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St Gabriel's Nursing Home
<b>Centre ID:</b>	OSV-0000174
<b>Centre address:</b>	Glenayle Road, Edenmore, Dublin 5.
<b>Telephone number:</b>	01 847 4339
<b>Email address:</b>	nursingstgabriels@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	SGNH Limited
<b>Provider Nominee:</b>	Phyllis O'Neill
<b>Lead inspector:</b>	Sheila McKeivitt
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	59
<b>Number of vacancies on the date of inspection:</b>	5

## 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: 22 April 2016 09:30 To: 22 April 2016 16:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

**Summary of findings from this inspection**

This was an unannounced inspection which took place over one day and was for the purpose of monitoring progress further to ten non-compliant outcomes from the last inspection in February 2015. The inspector found six of the ten outcomes were now in compliance however, four outcomes remained non-compliant.

The 66 bedded centre is spread over two floors. There were two residents in hospital and five vacant beds on the day of inspection.

The provider operates as a limited company and consists of four directors. Changes had taken place to the provider nominee since the time of the last inspection, and the Authority had been provided with full and complete information on the new provider nominee. She had been interviewed at the time of this change to ascertain fitness to undertake the role and responsibilities therein.

The management team was present for this inspection. Management systems had been developed and implemented to ensure communication between team members

was robust and to ensure the service provided was safe, appropriate, consistent and effectively monitored. However, some monitoring systems required further development.

The inspector noted that improvements had been made in relation to notifying Hiqa by the regulations. Records and investigations into incidents including reports of alleged abuse had improved. The policy had been reviewed and updated with template documents. Medication management systems had been reviewed and were now consistently monitored and improvements were noted. The management of risk in the centre had been completely reviewed, staff had received training, the policy reviewed, a risk register developed and a health and safety statement put in place.

Staffing levels and supervision practices had improved. There was now a minimum use of agency staff. Further training had been provided to staff and the supervision of practices increased. However, a need for further supervision was identified on this inspection.

The inspector found that residents' nutritional care provided was not to a high standard. This issue was highlighted on the last inspection and had not been satisfactorily addressed. Although staffing levels were found to be generally adequate on the day of the inspection improvements were required relating to competencies of registered nursing staff and supervision of clinical care and documentation.

The areas for improvement are discussed further in this follow up-report and are included in the action plans at the end of this report

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

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

There was a clearly defined management structure in place. Members of the management team had clearly defined roles and responsibilities. The inspector saw effective management systems had been put in place since the time of the last inspection on 13 February 2015.

The newly appointed provider nominee attended the centre on the day of inspection. The person in charge, assistant director of nursing and one of the two clinical nurse managers were also on duty. Communication between all members of the team was good. There was evidence that clinical and non clinical governance meetings occurred on a two weekly basis and operation meetings occurred every week. Clear, concise and detailed minutes of these meetings were available for review.

An audit calendar was in place for 2016. Clinical care areas being audited included falls, use of restraint, use of psychotropic medications, complaints, medication errors, weight loss and care plans. The care plan audit completed in February 2016 appeared to be detailed and provide favourable results. However, the care plan and weight loss audit had not detected that residents' were not being weighed as per their nutritional care plan. Hence, the audit tools and standard of auditing required review to ensure all areas of care delivery were being audited in a detailed manner.

An annual review had been completed in September 2015 recommendations made were discussed at clinical governance meetings and these had or were in the process of being addressed. The inspector noted there was no evidence of residents' involvement in the annual review.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The directory of residents now included the date residents' who had deceased. However, the cause of death was not available for all residents. The person in charge explained these had been followed up upon, but were not yet made available to the nursing home.

**Judgment:**  
Compliant

**Outcome 07: Safeguarding and Safety**  
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.*

**Theme:**  
Safe care and support

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

**Findings:**  
The inspector was informed that a methodology template for use when investigating all forms of abuse had been developed. The policy had been updated to include this template.

The inspector was satisfied that residents' were protected in the centre. Incidents' of alleged abuse had been investigated and actioned in line with the centres policy. The inspector was informed of an incident of alleged financial abuse reported to the person

in charge on the day of this inspection. The alleged incident was reported as per legislative requirements and was being investigated.

**Judgment:**

Compliant

***Outcome 08: Health and Safety and Risk Management***

***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**

Safe care and support

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

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

**Findings:**

The non compliances on identified on the last inspection had been addressed.

The risk register had been reviewed since the last inspection. It now included clinical risks to residents such as choking and malnutrition together with environmental risks. This was a live document which was kept under review by the management team, having been last reviewed in April 2016. Risk management training had been provided to the person in charge, clinical nurse managers and some staff nurses in February 2015. All risks were being discussed by the management team at the clinical and non clinical management meetings. This was evidenced from the minutes of meetings reviewed as mentioned under outcome 2.

The inspector saw that health and safety representatives were completing environmental audits on a regular basis. Records of these audits were available for review and included all areas of the centre.

**Judgment:**

Compliant

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

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

**Findings:**

The inspector reviewed a sample of resident medication prescription and nurse signature charts and saw evidence that supplements were being signed as having being administered as prescribed.

The medication audit tool had been adjusted to include food supplements, hence, this area of practice was been closely monitored by the management team.

**Judgment:**

Compliant

***Outcome 10: Notification of Incidents***

***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**

Safe care and support

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

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

**Findings:**

HIQA had been notified of all incidents and accidents which had occurred in the centre. The inspector was informed that the midday handover of care provide had lead to increased communication between staff caring for residents'.

**Judgment:**

Compliant

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

Residents' identified as at risk of malnutrition were not being provided with a high standard of care.

The inspector reviewed a sample of four residents' files who were identified as at risk of losing weight. Residents had risk assessments completed which identified them as at risk of malnutrition. All four had person centred care plans in place which detailed the frequency that their weight should be recorded however, the inspector observed that residents' were not being weighed as directed in their care plan. There was no recorded reason as to why this care was not being provided. For example, one residents' care plan stated to weight monthly, however, there was no weight recorded for this resident in October or November 2015, the resident lost 7kg between September and December 2015 and despite this significant weight loss the resident was not weighed in January 2016. The resident lost a further 4kg between December and February 2016. The resident was reviewed by a dietician in mid March 2016.

The inspector noted that recommendations being made by multi-disciplinary team members were not being followed through by nursing staff. In addition, care plans were not being consistently updated to reflect recommendations made by multi-disciplinary team members. For example, one resident identified as at risk of malnutrition in September 2015 was reviewed by a dietician in October 2015 who recommended the resident be weighed bi-monthly. However, the residents' weight had not been recorded in November or December 2015. In January 2016 the residents' weight was recorded, it was not completed in February or March 2016 and in April 2016 when the residents' weight was recorded a loss of 10kg was noted since January 2016. The inspector was informed that the resident had been referred to a dietician and they were waiting for the resident to be re-assessed.

Equipment to weigh residents' was available for use. However, the inspector was informed that the hoist used to weigh residents' was broken for a period of time. Due to an outbreak of infection in the centre, the repair personnel could not access the centre to repair the hoist. However, a sit on scales was available and a number of residents' whose weight had not been recorded were weighted using these scales.

Records reflecting residents' fluid and food input and output had improved since the last inspection. Residents awaiting review by the dietician had a three day food and fluid intake chart completed and awaiting review. There was evidence that residents' and/or their next of kin were involved in the assessment and care plan reviewed. However, reviews were not always taking place on a four monthly basis.

**Judgment:**  
Non Compliant - Major

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

**Theme:**

Effective care and support
<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> The findings of this inspection confirmed good provision of dining space in the main dining room situated on the ground floor. It was bright and spacious. Residents spoken with confirmed they enjoyed eating their meals in this space. The provider had extended dining space in the assisted dining room beside the sun room. The inspector saw residents' who required assistance having lunch in this room which was a lot quieter than the main dining room.</p> <p>Meals were also serviced to residents' who choice to take their meal in the communal day spaces on each floor. Food was delivered to these areas via a heated food trolley. The furnishings and seating in these communal rooms were more suited to sitting rooms. The inspector observed that there had been no provision of appropriate dining tables and chairs to these areas to date. The plan to increase the size of the upstairs communal area had not been actioned to date.</p> <p>The inspector observed that the provider was in compliance with all conditions of their certificate of registration. The resident occupying room 38 was independently mobile and room 39 was vacant.</p>
<p><b>Judgment:</b> Non Compliant - Moderate</p>

<p><b><i>Outcome 15: Food and Nutrition</i></b> <b><i>Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.</i></b></p>
<p><b>Theme:</b> Person-centred care and support</p>
<p><b>Outstanding requirement(s) from previous inspection(s):</b> The action(s) required from the previous inspection were satisfactorily implemented.</p> <p><b>Findings:</b> The inspector saw that residents' were offered a choice of meal at mealtimes. However, the type of protective clothing used required review as those in use did not appear dignified. In addition, the storage of a food waste container and of dining tray storage units required review as the proximity to residents' dining area took from the dining experience.</p>
<p><b>Judgment:</b> Compliant</p>

**Outcome 18: Suitable Staffing**

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

**Theme:**  
Workforce

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

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

**Findings:**

The skill mix and numbers were adequate to meet the needs of residents. Staffing levels had improved since the last inspection.

Staffing rosters were fully maintained. There was minimum use of agency staff however, those rostered to work were reflected on a roster.

Supervision had increased, nursing staff were observed supervising lunch in each of the dining areas. However, further improvements were necessary to ensure nursing care was being provided as per residents' care plan and in accordance with best practice as referred to under outcome 11.

The inspector saw evidence that staff had received training in the following areas; risk management, clinical documentation, cardio-pulmonary resuscitation, dementia care, fire, protection of residents and modified diet. Staff had not received refresher infection control training, since the recent outbreak of an infection in the centre. The inspector was informed that this was planned for a date in May 2016.

Staff meetings took place and the inspector saw minutes of these meetings. A staff appraisal system had been decided upon and was in the process of being implemented by the management team.

**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:***

Sheila McKevitt  
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<sup>1</sup>

Centre name:	St Gabriel's Nursing Home
Centre ID:	OSV-0000174
Date of inspection:	22/04/2016
Date of response:	20/06/2016

#### 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 02: Governance and Management

##### Theme:

Governance, Leadership and Management

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

The annual review did not include evidence of consultation with residents and their families.

##### **1. Action Required:**

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

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

such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

There are presently bi monthly Resident's meetings and quarterly relative's meetings which are facilitated by an advocate from Sage. These meetings are minuted. A sample of the minutes of the last residents and relatives meetings are attached.

Our annual resident's and relative's satisfaction surveys are currently being completed.

Individual residents who do not have anyone to assist them with completion of the survey will be facilitated by a Sage advocate.

The information received in the surveys will be collated by the Provider Nominee and Person in Charge.

The information received from the surveys will be discussed weekly in the operations meeting and bi monthly in the clinical governance meeting.

All staff relevant to the key points will be asked to attend the weekly operations meetings where their individual responsibility relating to the resident and relative satisfaction surveys will be discussed. Their actions will be agreed with a specific time frame to be followed up on the following week at the next operations meeting.

The Provider Nominee will undertake the annual review.

Proposed Timescale: Survey forms to be returned by 30th June 2016.

Collation of survey information by 31st July 2016.

Completion of annual review by 30/09/2016.

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**Proposed Timescale: 30/09/2016**

**Theme:**

Governance, Leadership and Management

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

A review of management systems including audit practices was required to ensure the service was safe, appropriate, consistent and effectively monitored.

**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 PIC and her Deputy have reviewed the audit calendar to ensure that all audit tools

are capturing the necessary information.

A weekly Nutrition Audit Tool has been developed alongside the 2 monthly Nutrition audit tool and in place since June 10th to capture all vulnerable residents.

The audit tool now focuses on analysing all care needs for residents at high risk of malnutrition.

The detailed daily nursing handover sheet- a live document- will record each resident at high risk of malnutrition.

The PIC, her deputy, and one of the CNM's attend the morning handovers with Nurses and carers where every resident with a MUST of 2 or above individual care needs will be discussed alongside the audit findings.

At present fortnightly clinical governance meetings are attended by the PIC, her deputy, the Provider Nominee, and the clinical nurse managers.

In future all available staff nurses will also attend the bi monthly clinical governance meetings to give them a more in depth understanding of the overall clinical management of the centre.

Audit training has been arranged for all nursing staff and they will be facilitated to take responsibility for clinical audit. This will allow them to see the importance of comprehensive completion of documentation.

Audit outcomes will continue to be discussed at the bi monthly clinical governance meeting. Actions generated from the trend analysis will be allocated to the key nurses within an agreed time line.

A meeting has been arranged with all staff nurses on 27.06.2016 to inform them of HIQA non compliances and their responsibilities generated from this action plan.

The revised comprehensive weekly nutritional audit tool is attached alongside the amended audit calendar.

New audit tool – 01.06.2016  
Audit Calendar- June 20.06.2016

Proposed Timescale: Weekly Nutrition Audit Tool – 01.06.2016

**Proposed Timescale: 01/06/2016**

## **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:**

Nutritional care plans were not being consistently updated to reflect recommendations made by visiting multi-disciplinary team members.

Care was not being delivered as required/outlined in the residents nutritional care plans.

Residents' nutritional risk assessment and care plans were not consistently reviewed on a four monthly basis.

**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:**

Theme:

Effective care and support

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

Nutritional care plans were not being consistently updated to reflect recommendations made by visiting multi-disciplinary team members.

Care was not being delivered as required/outlined in the residents nutritional care plans.

Residents' nutritional risk assessment and care plans were not consistently reviewed on a four monthly basis.

**1. 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 two residents mentioned in the report who had lost a considerable amount of weight had documented conditions which led to this weight loss.

The PIC and her deputy have discussed the findings of the HIQA report and all non compliances regularly with staff at morning handover meetings. Formal meetings have been scheduled to advise staff of the latest action plans and their responsibilities in being accountable for same. Minutes of these meetings will be circulated.

All residents' weights and malnutrition risk assessments have been reviewed by the PIC's deputy and are complete. This information is captured in the weekly nutrition audit tool.

All residents will have a malnutrition assessment done at monthly intervals.

Residents identified as being at risk will continue to have a 3 day food charts completed for referral to the dietician.

All residents' weight differentials are being highlighted in the daily nurse's progress notes and discussed at the carer's midday meeting handover.

The catering assistants are now required to give a verbal handover to the CNM in the main dining room regarding the dietary intake of all residents.

A staff nurse is also present in the assisted dining room and on both floors in the sitting room where a few residents choose to dine.

The PIC has met with members of the multidisciplinary team ( MDT ) , including dietician and speech and language therapist, and has agreed a standardised documentation process which will ensure that the MDT's assessments and recommendations are also included in the daily progress notes as a priority entry which is highlighted in red. The weekly nutrition audit tool captures this practice.

Care Plans updated with Dieticians recommendations are included in weekly audit tool. Nutrition Care Plans being completed 4 monthly included in weekly audit tool.

The weekly audit tool will identify the key nurses responsible for any omissions in their residents care. The PIC's deputy will provide protected time to these key nurses to update the residents care and care plan on a weekly basis.

A meeting with the PIC, her deputy and the provider nominee has been arranged with all care staff for July 6th to inform them of HIQA non compliances and actions necessary to address them.

The PIC, her deputy, and one of the CNM's attend the morning handovers with Nurses and carers where every resident at risk and their individual care needs will be discussed alongside the audit findings.

The carers midday meeting handover is continuing and being supervised by the ADON and CNM.

All carers will be notified of the necessity of the completion of the 'Change in daily condition' forms. All required documentation, specifically nutrition, to be entered into the electronic recording system in epiccare by carers. This information informs the nurse's daily progress notes.

Midday carer's handovers will capture any reasons for a resident not being weighed. Dieticians continue to visit 6 weekly if not required for referral beforehand.

A 4 weekly menu cycle is currently being reviewed by a nutrition specialist for verification of variety, nutritional content and adequate calorie intake for all residents incorporating requests from residents and relatives meetings.

The resident's dietary information sheet with any new recommendations from the Dietician and /or speech and language therapist is completed by the staff nurse on duty and given to the chef on the day. The nurse records this in the daily progress notes as a priority entry in red for audit review purposes.

The senior nurses are completing a weekly nutrition audit using a newly developed audit tool. The results of this are being sent to the PIC and her deputy. Any required actions resulting from this audit are discussed with individual key nurses for each resident.

The ADON will ensure that individual key nurses are given protected time to facilitate them to complete all necessary actions.

Nutrition training has been arranged for all nursing staff for 22nd and 29th June 2016.

Proposed Timescale:

Health Care Assistants Meeting – 06.07.2016

Weekly reports and audit in progress and ongoing.

Nutrition Training – 22 and 29th.06.2016

Clinical Audit Training to be completed by 30/08/2016.

**Proposed Timescale: 30/08/2016**

## **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:**

Dining room space provided on the first floor was not adequate to meet the needs of residents'.

### **4. 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:**

An alternative area has been identified that can be furnished with suitable dining furniture should the needs arise.

As acknowledged by the Inspector there is good provision of dining space for all

residents on the ground floor.

There are a small number of residents who chose to have their meals in either sitting room. These existing residents prefer to eat at individual tables.  
There is a dining table available in one of the sitting rooms.

**Proposed Timescale:** 30/07/2016

### **Outcome 18: Suitable Staffing**

**Theme:**  
Workforce

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

Supervision of care being delivered is not robust enough to ensure nursing care is delivered to a high standard.

**5. 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:**

A number of staff nurses have attended a 'Management and delegation skills' training. The remainder are being facilitated to attend. Risk management training will also be provided for those staff that did not attend previously.

The PIC and the PIC's deputy will continue to conduct daily rounds to ensure that residents are receiving appropriate standards of care.

The appraisal system identifies key strengths and weaknesses of all staff. Where weaknesses have been identified appropriate measures have been put in place and monitored through ongoing supervision in the work place.

The use of agency staff will only be required in rare and extreme circumstances as a full complement of nurses will be reached by the beginning of August 2016. Following successful orientation we will identify quality link nurses for key areas of practice such as Nutrition, Falls and Pressure Ulcers.

Appropriate training will be provided to the respective staff.

Care planning, risk management and audit training have been arranged for all nursing staff. A rotation of Staff nurses will attend clinical governance meetings on a bi monthly basis.

**Proposed Timescale:**

Clinical Audit Training -30/08/2016  
Management skills - 30.08.2016  
Risk Management- 30.09.2016  
Quality Link Nurse programme-Mid October 2016

**Proposed Timescale: 31/10/2016**

**Theme:**  
Workforce

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

All staff had not received refresher infection control training post the outbreak of an infection in the centre in March 2016.

**6. 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:**

The infection outbreak was from 21/03/2016 to 13.04.2016

As discussed with the inspector during her visit on 22/04/2016 infection control training had been arranged and the first session took place on 03/05/2016.

This training is being provided by the ADON ongoing until all staff working at the centre have been facilitated to attend it. This includes Nursing and Care staff ,Facilities, Household and administrative. The ADON received her training at RCSI (Royal College of Surgeons Ireland) in September 2015 over six days. (Presentation attached)

**Proposed Timescale: 30/07/2016**