

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sligo Nursing Home
Centre ID:	OSV-0000363
Centre address:	Ballytivnan, Sligo.
Telephone number:	071 914 7955
Email address:	sligonursinghome@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Services Unlimited Company
Provider Nominee:	Pat Shanahan
Lead inspector:	Marie Matthews
Support inspector(s):	Damien Woods (Day 2)
Type of inspection	Announced
Number of residents on the date of inspection:	54
Number of vacancies on the date of inspection:	8

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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
06 October 2016 09:00	06 October 2016 19:30
07 October 2016 09:00	07 October 2016 16:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a registration renewal inspection. The provider had applied to renew the registration of the designated centre. As part of the inspection, the inspector met with residents, relatives and staff members. The inspector observed practices, spoke with residents and relatives, reviewed questionnaires completed by residents and relatives and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff

files.

Sligo Nursing Home is part of a group of nursing homes operated by Mowlam nursing home group. It is located in an urban area in the town of Sligo. The centre provides long term care to adults to 62 residents. There were 8 vacancies at the time of the inspection.

13 residents and 5 relatives completed a pre-inspection questionnaire which was reviewed by the inspector. The Inspector found that residents and relatives were generally positive in their feedback to the Authority and expressed satisfaction about the facilities and services and care provided. Some relatives raised concerns regarding the staffing levels particularly at night.

A new person in charge had recently taken up her post and a new clinical nurse manager was been recruited and was due to commence her post in November 2016. The inspector found that although new in post the person in charge had a good knowledge of the residents needs.

Governance issues were identified during the inspection. The inspector identified that there was poor clinical supervision of staff as some care plans were missing and some were poorly completed, not reviewed regularly and not linked to assessments. Recruitment procedures required review to ensure staff were appropriately vetted before working with vulnerable adults. The response by management to safeguarding issues also required review to ensure that residents were protected from abuse. Audits of the service were been completed but these were failing to identify the areas where improvements were required and there were inadequate systems to ensure that improvements were brought about in response to audit findings. The inspector also identified that the management of behaviours associated with dementia required review.

Risk management also required improvement to prevent residents from sustaining injuries as a result of a fall. Other areas where improvements were identified were in the management of complaints, the provision of appropriate advocacy for residents with dementia, and the deployment of staff to ensure adequate supervision of residents.

The range of activities particularly for those unable to participate in group activities or those who spent time in their room was very limited.

There was evidence of compliance in relation to medication management and a new medication administration system had been introduced since the last inspection. The centre was maintained in good standard of hygiene and repair, with assistive equipment provided to support residents. It was nicely decorated and furnished in a homely style. Refurbishment of the lower ground floor and a new drainage system had been completed in response to flooding of the area in December 2015.

The inspector met with the provider, person in charge, regional manager and clinical nurse manager at the end of the inspection to relay the serious findings. The provider and person in charge gave a commitment to inspectors to address the areas

of non compliances. Since the inspection, the provider has provided confirmation that Garda vetting has been acquired for 8 staff and he has assured the Authority that the remaining staff are not included in the duty roster.

The Inspector identified non compliances in ten of the eighteen outcomes reviewed. The actions required from this inspection are outlined in body of the report and the action plan at the end.

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: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The Statement of Purpose set out the services and facilities provided in the designated centre and contained all the requirements of Schedule 1 of the regulations. The Statement of Purpose was kept up to date and had been recently revised to reflect the new governance structure.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The inspectors identified significant issues in relation to the overall governance of the centre. The person in charge had left her position in March 2016 and interim management arrangements were in place until a new person in charge took up the

position in September. The centre is part of a large group of designated centres and has organisational management systems in place including regional and national managers however the inspector found that these systems were failing to ensure positive outcomes and evidenced based care for the residents. Poor clinical supervision of staff was evidenced by an absence of care plans for some residents' care needs and poor review of some care plans. This is discussed further under outcome 11.

The Inspector also identified that twelve staff including the new person in charge were recruited and on duty without the provider first ensuring they were vetted by an Garda Siochana. Staffing levels also were identified as unstable due to a high rate of staff absenteeism. The deployment of staff required review to ensure residents care needs were met and that residents were supervised at all times. This is discussed further and an action required under outcome 18.

Organisational auditing systems were in use and the inspectors saw that statistical information was collected in relation to falls, medication management, health and safety human resources and infection control. The auditing system did not however include all key performance indicators (KPIs) of care such as residents' weight loss, or unwitnessed falls, medicine management and nutrition. The audits completed also failed to identify the breaches of the regulations found by the inspector. There was no quality improvement plan developed based on audits in consultation with the residents.

The person in charge said she had regular meetings with the regional manager however a record of these meetings was not maintained. A new Clinical Nurse Manager CNM had been recruited and was scheduled to take up her position in November and the person in charge said this would allow her to concentrate on clinical supervision. Some notifications were not submitted in accordance with regulations. This is discussed under outcomes 7 and 10.

Judgment:
Non Compliant - Major

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that each resident had an agreed written contract and a guide to the centre was provided to each resident on their admission. The contract of care clearly summarised the complaints process, the visitors policy, services provided in the centre

and the emergency procedures.

A sample of residents' contracts of care was reviewed. Each contract was signed within one month of entering the centre. The contract included the services provided and the fees charged.

There was a residents' guide available containing all the information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy, and the services provided and referenced the complaints procedure.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The newly appointed person in charge was interviewed following the inspection to determine that she was knowledgeable regarding her responsibilities under the regulations and fulfilled the criteria required by the regulations in terms of qualifications and experience. She is a registered nurse and holds a full-time post. She completed various courses since qualifying as a nurse including a diploma in management studies and a degree in Palliative care.

Although new to the centre, she was familiar with the residents and could describe how residents care needs would be met from the admission process to end of life care.

She has dedicated time allocated to manage the clinical governance and administration duties. She told the inspector she was aware of the areas that needed improving and had a plan in place to ensure these areas were addressed.

Judgment:

Compliant

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):

No actions were required from the previous inspection.

Findings:

Inspectors found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable. Written operational policies were available to guide practice. The directory of residents contained all the information required by schedule three of the regulations and was maintained up to date.

Care and medical records and other records, relating to residents and staff, were maintained electronically however on review the inspector found that some care records were poorly completed and some care plans lacked sufficient detail to guide care.

Staff files reviewed were found to contain the information required in the regulations and information was organised so it could be easily retrieved. However, Garda vetting was not available for 12 staff working in the centre. This was brought to the attention of the provider at the feedback meeting and he was directed to the recently issued guidance from the Chief Inspector and requirement to adhere to the legislation.

Judgment:

Non Compliant - Moderate

Outcome 06: Absence of the Person in charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

A clinical nurse manager was identified as the person who would deputise in the absence of the person in charge. An additional clinical nurse manager has been recently recruited who will support the person in charge and deputise in her absence.

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):

No actions were required from the previous inspection.

Findings:

The systems in place to safeguard and protect all residents from abuse were not effective. Twelve staff including the person in charge had not been vetting by Garda Siochana prior to starting work in the centre.

Inspectors viewed records confirming there was an on-going program of refresher training in protection of vulnerable adults.

One incident recorded in the centres complaints log that occurred during the summer concerned a complaint that a resident made about a staff member failing to bring them to the bathroom. The inspector saw that the person in charge had investigated the incident and completed an assessment of the resident however, the person in charge at the time did not identify the incident as neglect / abusive practice. It had also not been appropriately reported to HIQA. On review the inspector saw no evidence to indicate that any staff member had been disciplined or retrained to prevent a reoccurrence.

There was a policy and procedure available which included information on various types of abuse and guidance on managing allegations/ incidents of elder abuse. Training records reviewed indicated that that staff had participated in training in the protection of residents from abuse.

There were systems in place to ensure residents' finances were appropriately safeguarded, however inspectors found that these also required review. An incident recorded in the complaints log concerned a resident's wallet containing money and personal belongings had been lost. Although the money was refunded by the provider, there was no evidence of any substantive investigation into where the wallet went and no evidence of any interview with staff. The incident had not been reported to the Gardai or to the Authority. There was a policy available on the management of residents' personal property and possessions however this was not reflected in practice.

The provider confirmed that he did not act as an agent for any residents. A petty cash system was in place to manage small amounts of personal money for residents. A record of the handling of money was maintained for each transaction. Two staff signatures were present for all transactions.

There were policies in place to guide staff on the management of behavioural and

psychological signs and symptoms of dementia (BPSD). The inspector reviewed the care plans of two residents with BPSD. There was evidence that staff had completed training to assist them caring for these residents and the inspector saw that residents were reviewed by the Psychiatry of Older Age Consultant however there were no specific behaviour support plans available with proactive and reactive strategies to guide and inform staff and to ensure a consistent approach to the management of the behaviours expressed.

There was a policy available on restraint management (the use of bedrails and lap belts) in place. A restraint/ enabler register was maintained and the staff were working to promote a restraint free environment. At the time of this inspection there were 18 residents with bedrails in use. This had reduced by 10 in the last quarter. Alternative options were considered before a bed rail was put in place. Some of the bedrails were documented as enablers. The inspector saw that where a bedrail was requested by a resident in order for them to feel safe or reposition them in bed, a risk assessment was completed to ensure the practice was safe however; the enabling function of the bedrail was not always recorded in the risk assessment. There was evidence that less restrictive options were considered prior to the use of the restraint and signed consent was obtained.

There was some evidence that residents with bedrails were checked on regularly throughout the night but night-time checks on residents was an area identified by the inspector which required improvement. This is discussed further under outcome 18.

Judgment:
Non Compliant - Major

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The inspectors found that while risk management policies and procedures were in place there were gaps in the way these were put into practice. Inspectors reviewed the accident and incident log for the preceding 6 month period including the care records of a resident recently admitted. 50% of all falls incurred by residents were unwitnessed. The arrangements for learning from accidents and incidents were inadequate. Some falls prevention care plans reviewed were not accurate and had not been updated to reflect the residents increased injury risk due to repeated falls.

Inspectors reviewed two accidents incurred by one resident since admission. The admission assessment clearly identified that the resident had a history of falling and was at high risk of sustaining further falls. The need for continuous supervision of the resident was noted in the assessment. A falls prevention care plan was not however developed within 48 hours of admission to guide staff and to minimise the risk of further falls and no interventions had been put in place. Inspectors saw that this resident sustained two falls on the night of admission. There was no evidence that any safety precautions had been put in place to prevent further falls. This was brought to the attention of the person in charge immediately by the inspectors.

Some accident forms were observed to be incomplete and neurological observations were not always recorded when a resident had sustained an unwitnessed fall or had a suspected head injury. Where neurological observations were recorded by staff, they were not been monitored every fifteen minutes initially in line with evidence based practice.

Staff had completed training on moving and handling and were observed by the inspector to implemented good practice when assisting residents. There were low-low beds, crash mats and sensor mats available to reduce the occurrence of falls. A physiotherapy service was available in the centre. All residents who fell were seen by the physiotherapist.

Fire safety measures were in place but there was inconsistent recording of daily checks on fire escape routes. In discussions with staff the inspectors learned that fire safety checks were completed by a maintenance staff member and were not done when the staff member was off duty.

Fire and smoke containment and detection measures were in place. Emergency lighting, fire fighting equipment and directional signage were available throughout the building. The inspector evidence that fire equipment and emergency lighting were serviced regularly. All exits routes were noted to be free of obstruction.

Staff had received training in fire safety within the past 12 months and those interviewed were familiar with what actions to take in the event of a fire. There was evidence that fire drills were completed at regular intervals.

Risk management policies, procedures and systems were in place to assist in the identifying, assessing and taking precautions to control/minimise risks. A risk register was available and had been updated. The inspector observed that the centre and the grounds around the centre were visibly clean and clutter free. On walking round the premises, inspectors noted that there were systems in place keep residents safe. For example, the premises were well maintained, equipment was stored appropriately, an emergency call bell system was available, handrails were provided in circulating areas and the centre was free from clutter. Grab support rails were provided in shower and toilet areas.

Key pad locks were provided on the entrance and a visitor's book was in use. A missing person policy was in place to guide and inform staff should a resident be reported as missing. Photographic identification was available for each resident on the electronic

care planning system.

An emergency plan was in place to guide staff in responding to untoward events such as power failure and loss of heating identified. Contact details for local services were included and details of alternative accommodation for residents were provided in the event of an evacuation.

There were measures in place to control the spread of infection. Hand sanitising gels were provided throughout the centre and a colour coded cleaning system was in use. Separate cleaning equipment was used to clean bedrooms and bathrooms in accordance with the good practice.

Judgment:

Non Compliant - Moderate

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:

Medication was administered in accordance with Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) for nursing staff. A separate medication trolley was provided for each floor and this was stored safely when not in use.

A new medication administration system was in use since the last inspection. Medication was delivered to the centre by the pharmacist in individual weekly blister packs. The inspector accompanied a nurse for the lunchtime medication round. The prescription sheets were pre-printed and each medication was individually signed for by the General Practitioner. Photographic identification was available for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible. The inspector saw that the maximum amount for (PRN) medication (a medicine only taken as the need arises) was indicated on the prescription sheets examined.

The medication administration sheets were signed by the nurse following administration of medication. Medication was administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked.

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):

No actions were required from the previous inspection.

Findings:

The inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to the Authority as required however as discussed under outcome 7, an incident of suspected abuse was not identified as such and had not been appropriately notified to the authority.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

There were 54 residents in the centre during the inspection. 25 with maximum dependency care needs, 10 residents were assessed as highly dependent, 12 had medium dependency care needs and six residents were assessed as low dependency. Most residents had a range of age related healthcare issues and the majority had more than one medical condition.

There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, dietician, tissue viability specialists, physiotherapy and speech

and language were also available.

An electronic system was used to record information about residents. Inspectors were given access to the system. There was evidence that pre-admission assessments were undertaken to ensure that the centre could meet the needs of individual residents. Prospective residents were visited at home or in hospital or were invited with their families to visit the centre prior to making a decision to live there. Comprehensive assessments were carried out to assess each resident for risk of malnutrition, falls, levels of cognitive impairment and skin integrity.

In general the inspector saw that a care plan was developed within 48 hours of admission based on the resident's assessed needs; however there was inconsistency in the completion of care plans. Some were completed to a good standard but some were not detailed enough. There was no care plan developed for one resident who was admitted a week prior to the inspection.

Some care plans reviewed were generic and lacked sufficient detail to guide care and to give a clear overview of the residents care needs. For example a care plan for a resident with weight loss stated that the resident should be weighed regularly but did not state the frequency that weighing should be completed. The inspector also saw that some care plans had not been reviewed in over four months.

Where there was a change in the residents' condition, this was not always reflected in the care plan. For example, one resident had been reviewed by a dietician. The inspector saw that the resident was getting the food supplements prescribed, however, the nutritional care plan had not been updated to reflect the revised advice of the specialist. Another resident who was immobile due to a neurological condition had a misleading falls care plan stating they were at high risk of sustaining a fall. Where residents had impaired mobility and required a hoist for transfer, the care plans did not reference the sling size they required for a hoist. There was also poor evidence in some care plans reviewed that the resident or his or her family were involved in the reviews of the care plans.

Two of the residents had developed pressure wounds. The inspector reviewed one wound care plan which evidenced that the resident was appropriately referred to a tissue viability specialist and the wound had healed. Residents with impaired skin integrity had appropriate pressure relieving mattresses and cushions in place.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The centre is configured over two floors and was designed to meet the needs of dependent older people. The inspector found that it was warm, comfortable, well decorated and visually clean. A safe enclosed garden was available to residents. The basement area which was flooded during December 2015 had been refurbished and a good standard of décor was evident. Maintenance staff were employed and service contracts were in place to ensure the maintenance and repair of equipment such as the lift, boiler and assistive equipment. There are a variety of communal areas available for residents including a sitting and dining rooms and a visitors' room. In total there are 30 single en-suite bedrooms and 16 double en-suite bedrooms. All en-suites were observed to be fully accessible and privacy screens were provided between beds in the double rooms. Televisions were provided in all bedrooms. There was a nurse's station provided on each floor. There were a sufficient number of toilets, baths and showers provided for use by residents and toilets were located close to communal rooms for residents' convenience.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 13: Complaints procedures</i> <i>The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.</i></p>
<p>Theme: Person-centred care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Complaints management required review. Some complaints were not recorded and some did not appear to be adequately investigated. The inspector spoke with a resident who felt staffing levels were inadequate. The resident said he had relayed these concerns to management but there was no evidence that this was recorded or investigated . In some complaints recorded the complaint record did not indicate if the resident was satisfied with the outcome or if details of the appeals process had been given to the resident.</p> <p>The complaints policy and the procedure for making a complaint were displayed in the reception area. A comments /suggestion box was also available to collect feedback from</p>

residents and visitors to the centre. In the feedback to the inspector and in the questionnaires returned by both residents and relatives, people felt they could complain to the person in charge or any staff if they had any concerns.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy on end-of-life care to guide staff and the local palliative care team provided support and advice when required. Each resident had an end of life care plan. Some care plans reviewed by the inspector contained good detail regarding the residents' personal and spiritual wishes while others reviewed were generic and the template used had not been updated with the residents' individual preferences and spiritual wishes.

The inspector reviewed the end of life care plan and care notes of a recently deceased resident. The resident's end of life wishes were clearly recorded. There was evidence in the daily medical notes that the residents' spiritual needs were attended to and that the residents' family were present to support the resident.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found that there were systems in place to ensure residents received good nutrition however these were not always implemented. Each resident was screened for nutritional risk on admission using a recognised assessment tool. Where a resident was identified as been at risk nutritionally they were referred to a dietician and those who had an impaired swallow were reviewed by a speech and language therapist. The inspector saw that residents' weights were checked monthly and more frequently where indicated by a dietician. In some of the care plans reviewed however the advice of these specialists was not incorporated into the residents nutritional care plan.

The inspector met with the chef who had a list with names of each resident who required a modified diet and those on special weight reducing or diabetic diets. On review of one resident however, the inspector found that the dietary requirements had changed and the list had not been updated. The inspector verified that the resident was receiving the correct consistency diet however this could cause confusion.

There was a good variety of home baking provided daily for residents including scones, buns and brown bread. The chef helped improve the appearance of some of the prescribed food supplements by decanting them from their containers and presenting them in dessert bowls and presenting them with fresh fruit or fruit puree and fresh cream. The chef also made fruit smoothies for residents and fortified the diets of residents with weight loss.

The inspectors observed the residents during their lunch time meal. The menu was displayed in the dining room and there was a choice of meals provided. Staff provided assistance to residents in a respectful unhurried manner and encouraged them to eat their meal at their own pace. Residents with an impaired swallow were seated in an upright position in accordance with the advice of the Speech and Language therapist to prevent aspiration

Water, milk, tea and coffee were available throughout the centre and jugs of water were observed in residents' rooms, however inspectors were concerned that the systems for ensuring residents had sufficient fluids was not adequate and better supervision of residents' hydration was required particularly for those residents in bed. The inspector visited one resident in her bedroom on the afternoon of the second day of the inspection. There were drinks from breakfast and from lunch untouched on the residents table. This was immediately brought to the attention of nurse on duty.

Judgment:

Non Compliant - Moderate

Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

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

Findings:

There was evidence that residents rights, privacy and dignity was respected. Staff were observed to interact with residents in a personal manner. Privacy screens were provided in shared bedrooms and all personal care was delivered in the resident's bedroom. All bathrooms had privacy locks fitted.

The foyer at the entrance to the centre was used for meeting visitors in addition to a visitor's room and some residents were observed visiting with family or friends. There were no restrictions to visiting in the centre.

Residents' meetings were held at regular intervals however there no relatives actively attended the meetings and there was no independent advocate available for residents who had a cognitive impairment or could not attend the meetings. This was also identified on the last registration inspection and the provider stated in the action plan that 'all future residents meetings would include the relatives of cognitively impaired residents to represent their views. Residents were facilitated to exercise their civil, political and religious rights. Mass was also held in the centre one other day each week.

The inspector observed that residents' communication needs were generally highlighted in their care plans however; the inspector reviewed one resident's care plan who experienced impaired communication. There was no evidence that any efforts had been made to purchase assistive technology to aid communication and improve the resident's quality of life. The inspector saw that some residents spend long periods of time in their bedroom. There was poor evidence of any attempts to provide any meaningful one to one activities to suit the needs, interests and capacities of these residents.

Comments in the residents' questionnaires confirmed that residents were happy and that their rights were respected. Most of the commentary regarding activities available was positive. Both relatives and residents commented that was a good range of organised activities to keep residents engaged in a meaningful way. One resident commented however that he was bored. A schedule of activities was displayed which included skittles, newspaper reading, music, flower arranging. A number of musicians also regularly attended the centre. An activity coordinator was employed five days a week between the two floors. Three care staff had also completed Sonas training (a therapeutic activity for residents who are cognitively impaired).

Staff were observed knocking on bedroom, toilet and bathroom doors and waiting for a response to enter and this was confirmed by residents. The inspector observed staff interacting with residents in a friendly and courteous manner.

Judgment:

Non Compliant - Moderate

***Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can***

appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector saw that each bedroom had adequate secure space for residents' personal possessions and clothing. Clothing was labelled to aid identification. The Inspector observed that property lists were maintained for residents however on review the inspector found that these were not detailed and were not always updated when new items were brought to the centre.

There were arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents. A staff member was assigned to the laundry seven days of the week.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

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

Findings:

The centre is arranged in two units each over two floors. A copy of the staffing roster was reviewed by the inspector. The normal allocation of staff on duty was three nurses and eight care assistants during the day from 08.00 until 2pm. This reduced to two nurses and seven care assistants in the evening until 20.00. At night time there were two nurses and three care assistants on duty. From analysis of the questionnaires returned by residents and families, staffing levels was a constant theme. There was no system to record regular checks on residents who were in bed during the day or at night

time. As discussed under outcome 8, one resident assessed as requiring constant supervision by staff had not been adequately supervised and had as a result sustained falls.

Communal areas were regularly unsupervised during the inspection and there were a high number of unwitnessed falls occurring. The provider was requested to complete a review of the staffing levels and staff deployment to ensure that there were sufficient staff who were appropriately deployed to meet the assessed needs of residents.

The recruitment process was not effective at ensuring all staff had all of the information required by schedule two of the regulations. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers were available for nursing staff however 12 staff including the person in charge did not vetting by Garda Síochána. An action has been included under outcome 7 requiring the provider to address this and the provider was requested to submit written confirmation that all staff have been appropriately vetted .

A training plan for 2016 was available and it included all mandatory training courses as well as training on clinical areas such as care planning, infection control, and the management of behaviours associated with dementia. The training provided on care planning did not appear to be implemented in practice. There was an apparent lack of clinical supervision of staff to ensure that care plans were been appropriately completed and reviewed which was evident from the findings in outcome 11.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Marie Matthews
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 report¹

Centre name:	Sligo Nursing Home
Centre ID:	OSV-0000363
Date of inspection:	06/10/2016
Date of response:	30/11/2016

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:

Management systems were failing to ensure positive outcomes and evidenced based care for the residents. There was no records maintained of management meetings to evidence that management systems were ensuring that the service provided is safe, appropriate, consistent and effectively monitored.

1. Action Required:

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

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:

- There is a schedule of meetings in place for the home. This includes a monthly management team meeting where the quality and safety of care and the operational aspects of the nursing home are discussed. The minutes of this meeting will identify and document required actions and these will be communicated to appropriate staff and compliance with agreed actions will be monitored by the PIC within an allocated time frame.
- The PIC will direct care and supervision in line with home policies. All policies in the home are based on regulatory requirements, national standards and evidence-based principles of care.
- All incidents, complaints and concerns will be reported and documented. The PIC will investigate and produce an action plan which will be communicated to the appropriate staff. The PIC will monitor compliance with agreed actions.
- The Healthcare Manager will support the PIC in the development of appropriate evidence-based action plans.

Proposed Timescale: 31/12/2016

Theme:

Governance, Leadership and Management

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

There was no quality improvement plan completed developed based on audits in consultation with the residents.

2. 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 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:

- The PIC will complete Mowlam Audits as per the agreed schedule and will develop action plans to be allocated to appropriate staff.
- The PIC and CNM will ensure that actions are completed and reflect a positive outcome for the residents.
- A quality improvement plan will be developed on the basis of the outcomes of the Mowlam auditing system, reviews of incidents and complaints and reviews of risks and clinical indicators. The quality improvement plan will incorporate the findings from the Customer satisfaction survey and Resident meetings.

Proposed Timescale: 30/11/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Some care records were poorly completed and some care plans lacked sufficient detail to guide care.

3. Action Required:

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

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

- A systematic review of all resident assessments and care plans is currently in progress.
- The PIC and CNM will ensure that all care plans are developed with the residents and their representatives and that all care delivered is based on the individual assessed care needs and in accordance with the resident's wishes and preferences.
- The PIC will ensure that all nurses receive training and education in relation to assessment and care plan development.
- Assessments and care plans will be reviewed and updated as the residents' care needs change and in line with regulatory requirements.
- The resident's care plan will be person-centred and will communicate and facilitate the delivery of high quality, evidence-based care.

Proposed Timescale: 31/03/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

The person in charge did not identify two incidents as abuse and take appropriate action to safeguard residents.

4. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

- The safeguarding policy in the home is in accordance with the National Policy on Safeguarding Vulnerable Persons at Risk of Abuse. All allegations and/or incidents of suspected abuse will be investigated in accordance with this policy.

- The PIC will ensure that all staff receive further education and awareness training in the identification and response to safeguarding issues within the home.
- All incidents and safeguarding actions will be reviewed at Monthly Nursing Home management team meeting.

Proposed Timescale: 31/12/2016

Theme:

Safe care and support

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

The recruitment process was not effective at ensuring all staff had all of the information required by schedule two of the regulations. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers were available for nursing staff however 12 staff including the person in charge did not vetting by Garda Síochána.

5. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

- All employees will commence employment in the home only when confirmation of the Garda Clearance has been received.
- All outstanding Vetting of current staff has been completed and clearance certificates are in the employee files.

Proposed Timescale: 22/11/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

The arrangements for learning from serious incidents were inadequate and some falls prevention care plans were not in place or were not accurate or had not been updated to reflect the residents increased risk.

6. Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

- The Risk Management policy includes measures and actions in place to control

accidental injury to residents, staff or visitors to the home.

- The PIC will ensure that all physical and environmental risks are recorded on a risk register in the home.
- The PIC will ensure that all incidents are reported, documented and assessed, including the requirement to notify incidents to the Authority. She will ensure that appropriate interventions are developed, communicated to staff and documented in the care plan.
- Clinical risk assessments will be reviewed following all serious incidents. The assessment and action/ intervention plan will be communicated to all appropriate staff and the resident's care plan will be updated to reflect the interventions required to reduce the risk of recurrence.
- Learning outcomes and improvements to care and service will be documented when incidents/complaints are closed.

Proposed Timescale: 31/12/2016

Theme:

Safe care and support

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

There was inconsistent recording of daily checks on fire escape routes. Fire safety checks were not completed every day.

7. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

- The PIC will ensure that all fire safety checks are completed and documented as per policy.
- The PIC will ensure that checklists are not allocated to specific staff members, but rather incorporated into the care team daily routine.
- The PIC and CNM will ensure compliance with the recording of daily fire safety checks.

Proposed Timescale: 30/11/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

An incident of suspected abuse was not identified as such and had not been appropriately notified to the authority.

8. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

- All incidents of alleged or suspected abuse will be notified to the Authority within the designated time frame.
- Training and education updates will be scheduled for all staff in relation to identifying and responding to resident safeguarding issues.

Proposed Timescale: 31/12/2016

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:

One resident who was admitted over a week did not have any care plans developed.

Where there was a change in the residents' condition, this was not always reflected in the care plan.

Some care plans were generic and lacked sufficient detail to guide care and to give a clear overview of the residents care needs.

9. 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:

- Prior to admission, the PIC will undertake a thorough pre-admission assessment of resident's care needs to ensure that the home can cater for the care needs of each resident.
- The PIC will ensure that a comprehensive assessment of resident care needs is documented on admission.
- This comprehensive assessment will serve to inform initial care plan development in line with the resident's needs and personal preferences/wishes.
- Care plans will be resident focused and based directly on the assessed care needs and personal wishes of the residents.
- Care plans will be communicated to all care staff through increased and improved clinical and care supervision.
- Nurses and care staff will discuss individual resident care plans on a regular basis and care staff will be encouraged to advise nurses on any changes to the required plan of care.

Proposed Timescale: 31/03/2017

Theme:

Effective care and support

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

. Some care plans had not been reviewed in over four months.

10. 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:

- Care plans will be reviewed and updated in line with any changes in the resident's assessed care needs or medical condition.
- Care plans will be developed with the resident and their representatives and can be reviewed, changed or updated at any time.
- Care plans will be reviewed at least 4 monthly, in line with regulatory requirements and national standards.

Proposed Timescale: 31/03/2017

Theme:

Effective care and support

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

Neurological observations were not always recorded where a resident sustained an unwitnessed fall or a suspected head injury. Where neurological observations were recorded they were not monitored every fifteen minutes initially in line with evidence based practice.

11. 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:

- All nurses will be directed to complete Neurological observations following an unwitnessed fall or a suspected head injury.
- Neurological observations are now being recorded every 15 mins post injury as per home policy.

Proposed Timescale: 30/11/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

There was no indication in some complaints reviewed that they were adequately investigated, that the outcome was relayed to the complainant or that they were satisfied with the outcome.

12. Action Required:

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

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

- All complaints will be fully investigated in line with the centre's complaints policy. Investigations relating to all complaints will be recorded and documented in line with the centre's policy.
- Complainants will be contacted with the outcome of the complaint and their level of satisfaction will be documented.
- All complaints will be reviewed at the monthly nursing home management team meeting and learning outcomes will be developed.

Proposed Timescale: 30/11/2016

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

The systems for ensuring residents had nutritious food and sufficient fluids was not adequate and better supervision of residents' nutrition and hydration needs was required.

13. Action Required:

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

- The PIC ensure the nursing and care staff work with the Catering team to ensure the nutritional requirements of all residents are met.

- All Nutritional risk assessments (MUST) and all Nutritional care plans will be reviewed.
- All nutritional care plans will be communicated directly to the catering and the care teams.
- Nutritional risk assessment (MUST) and Nutritional care plans will be part of regular care planning discussions.
- Greater supervision of nutritional intake of food and fluids has been commenced.

Proposed Timescale: 28/02/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The inspector observed that some residents spend long periods in their bedroom. There was poor evidence of any attempts to provide any meaningful one to one activities to suit the needs, interests and capacities of these residents.

14. Action Required:

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

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

- The Health & Wellbeing/social care plan will be reviewed and developed to enhance and improve the social care needs and quality of life of each resident.
- The nursing team will work with the resident, their representatives, the Activity coordinator and care staff to ensure that a resident centred, care plan is developed which reflects the social needs of each resident.
- All staff will receive ongoing training in relation to the promotion of the Social Model of Care, respectful and dignified delivery of care and Safeguarding of residents.

Proposed Timescale: 31/03/2017

Theme:

Person-centred care and support

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

There were no relatives actively attending the resident meetings and no independent advocate available for residents who had a cognitive impairment or could not attend the meetings.

15. Action Required:

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

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

Residents' families will be invited to attend scheduled meetings and to actively participate in the lives and activities of the family members in the home.

- An independent advocate will be sourced via SAGE, with a view to attending resident forums to advocate for residents unable to participate in the development of the home.
- Residents' meetings will be given greater focus and action plans will be developed to address issues raised.

Proposed Timescale: 31/01/2017

Theme:

Person-centred care and support

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

There was no evidence that any efforts were made to use assistive technology to aid residents with impaired communication to communicate and improve the residents' quality of life.

16. Action Required:

Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

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

- The PIC will ensure that the nursing team develop a plan with the resident/representative, nurses and the care team which address the resident's assessed communication needs and their personal wishes.
- The PIC will ensure that appropriate referrals are made for residents who require review of vision and hearing.
- Appropriate interventions will be sourced and evaluated for quality of life improvements.
- Care plan will be reviewed by the CNM.

Proposed Timescale: 28/02/2017

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

property lists were maintained for residents however on review the inspector found that these were not detailed and were not always updated when new items were brought to the centre.

17. Action Required:

Under Regulation 12 you are required to: Ensure that each resident has access to and

retains control over his or her personal property, possessions and finances.

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

- A detailed property list will be completed for each resident as part of the admission process. The resident/relative will sign the property list which will be filed in the resident's bedroom where it can be reviewed and updated as required.
- The PIC and CNM will ensure compliance with this policy.

Proposed Timescale: 31/12/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The number and skill mix of staff was not appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

18. 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:

- The number and skill mix of staff will be based on the number of residents, their assessed care needs and the geographical layout of the centre.
- The PIC will ensure the number of staff on duty takes account of the number and dependency levels of residents and that there are systems in place to ensure appropriate supervision of residents at risk of falls and there is more effective supervision of communal areas.
- An Assistant Director of Nursing will be appointed in December, who will enhance the leadership and supervision of nurses and care staff and will monitor the quality of care and allocation of staff on a daily basis.
- Further education and training of staff will take place on care planning and the quality of clinical documentation.
- The PIC will ensure that sufficient staff are on duty to deliver direct care and to ensure that the residents are supervised and protected from harm. Resident safety will take priority in all staffing decisions.
- Care staff will receive continuing direction, delegation and supervision from the CNM and nursing staff.

Proposed Timescale: 31/12/2016

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

There was an apparent lack of clinical supervision of staff to ensure that care plans were been appropriately completed and reviewed which was evident from the findings in outcome 11.

19. 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:

- Care plans will be reviewed and updated in line with any changes in the resident condition.
- Care plans will be developed with the resident and their representatives and can be reviewed, changed or updated at any time.
- Care plans will be reviewed at least 4 monthly, in line with regulatory requirements and national standards.
- Assessments and care plans will be reviewed regularly by CNM to ensure compliance.

Proposed Timescale: 31/01/2017

Theme:

Workforce

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

The recruitment process was not effective at ensuring all staff had all of the information required by schedule two of the regulations. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers were available for nursing staff however 12 staff including the person in charge did not vetting by Garda Siochana.

20. 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:

- Potential employees will only commence employment in the Nursing home after confirmation of vetting clearance by An Garda Siochana.
- All outstanding Vetting of current staff has been completed and clearance certificates are held on employee files.

Proposed Timescale: 22/11/2016

