

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Gahan House
Centre ID:	OSV-0000545
Centre address:	High Street, Graiguenamanagh, Kilkenny.
Telephone number:	059 972 4404
Email address:	mmulligangahanhouse@eircom.net
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Graiguenamanagh Elderly Association Limited
Provider Nominee:	Val Lonergan
Lead inspector:	Ide Cronin
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	12
Number of vacancies on the date of inspection:	0

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: 11 August 2016 09:00 To: 11 August 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	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This monitoring inspection was unannounced and took place over one day. As part of the monitoring inspection, the inspector met with residents and staff members. The purpose of this inspection was to monitor on going compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The inspector also followed up on areas of non compliance identified at the previous inspection which took place in March 2015. The inspector met with residents and staff members, observed practices and reviewed documentation such as care plans, medical records, policies and procedures. The inspector observed that staff interacted with residents in a respectful and caring manner. However, many of the actions from the previous inspection had not been adequately addressed and therefore were still outstanding on this inspection.

The centre is operated by a voluntary body. The centre caters for low dependent and

independent residents and if dependency needs of residents change alternative accommodation is sought for the resident. The care provided was based on the social model of care as residents had been assessed as not requiring full time nursing care. A nurse attended the centre ten hours per week over two days. The inspector was satisfied that residents were provided with suitable and sufficient care taking account of their health and social care needs in a supportive community based environment.

A total of ten outcomes were inspected. The inspector judged two outcomes as compliant, one outcome as major non compliant, six as moderate non compliance and one as substantially in compliance with the Regulations. The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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):

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

Findings:

The inspector was satisfied that the statement of purpose accurately described the aims, objectives and ethos of the centre and the service that was provided. The statement of purpose set out the services and facilities provided in the designated centre. It contained all the requirements of Schedule 1 of the Regulations.

The inspector noted that the statement of purpose was made available in the front reception area for residents, visitors and staff to read. The inspector observed that the statement of purpose had been reviewed in May 2015.

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):

No actions were required from the previous inspection.

Findings:

The clinical management structure was adequately resourced. However, it was not defined in terms of roles, responsibility and clear lines of authority and accountability. It

was not clear to the inspector that the governance systems in place demonstrated that the management team working within the service were aware of their responsibilities under the legislation. These findings are supported by the repeated non compliances identified throughout this report and it was not demonstrated that there was a clear commitment by the management team to promote and strengthen a culture of quality and safety.

The provider nominee confirmed that he attended the centre on a regular basis at least once per week. The provider was part of the group that established Gahan House in 1989. He has sat on the Board of Management since then. The Board of Management meets at least once a month. The person in charge confirmed that she attended the Board of Management meetings. However, there were no minutes of these meetings available on site for review by the inspector.

On the previous inspection the person in charge outlined her audit plan for 2015 and stated that the results of the regular audits would form part of the annual review of quality and safety of care. There were no audits available on the day of inspection. The person in charge said that a medication management audit had recently been completed. However, these records were not retrievable on the day of inspection.

An established system of auditing should be commenced to elicit any deficits within the service and disseminate feedback which would promote learning. Regular auditing would assess, evaluate and improve the provision of service in a systematic way in order to achieve the best possible outcomes for residents. Further practice development and change management is required to ensure staff are providing care in accordance with contemporary evidenced-based practice.

An annual review of the quality and safety of care delivered to residents had not taken place for 2015 as required by the Regulations. Although residents told the inspector that they were very happy with the care and services provided there was no evidence of what measures were planned to improve the quality of service delivered to residents. As there was no evidence of any information available to inform management decisions it was not possible drive continuous improvements in service provision.

There were no audit reports available on the day of inspection. There was no annual review of the service. There was no system in place for clearance from the Garda Vetting Bureau for volunteers. Based on these findings as outlined a judgment of major non compliance was made.

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

<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: Only the component of the Residents' Guide was considered as part of this inspection. A Residents' Guide and information brochure was available which included a summary of the services and facilities provided. The Residents' Guide included useful information about the local community. The inspector observed that copies were available in the reception area. On the previous inspection it was found that the Residents' Guide did not contain the following information:</p> <ul style="list-style-type: none"> • Procedure respecting complaints • arrangements for visits • terms and conditions relating to residence in the centre. <p>The inspector reviewed the Residents' Guide on this inspection and found that the Registered Provider had not amended the document to include the information that was required since the previous inspection. The Registered Provider had stated that in the response to the previous action plan this would be completed by June 2015.</p>
<p>Judgment: Non Compliant - Moderate</p>

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

<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: Information governance required improvement. The inspector found that either some records were not available on site for inspection purposes or records that were requested by the inspector were not retrievable as outlined throughout the report.</p>
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All of the policies as listed in Schedule 5 of the Regulations were not in place. For example there was no policy on communication or creation, access to destruction and retention of records. As on the previous inspection and outlined in the relevant outcomes, a number of policies listed in Schedule 5 did not contain implementation/review dates and therefore it was not clear if these policies had been reviewed in the previous three years. In the response to the previous action plan the Registered Provider stated that this action would be completed by June 2015.

Some improvements were required in Schedule 2 records – the documents to be held in respect of staff employed, were available but in the sample of files examined the information was difficult to find and needed reorganisation to ensure ease of retrieval of the required information. In a sample of four staff files reviewed by the inspector there was no photographic identification in a file and in another file there were no references present as required by the Regulations.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Measures to protect residents being harmed or suffering abuse were in place. A centre specific policy was in place for the prevention, detection and response to abuse. However, this was due for review and should incorporate the Health Service Executive (HSE) policy on Safeguarding Vulnerable Persons at Risk of Abuse 2014. There was a visitors log in place.

Staff with whom the inspector spoke with were clear and knowledgeable in relation to different types abuse and the steps to take in the event of an incident, suspicion or allegation of abuse. However, it was difficult to ascertain from training records reviewed whether or not staff had received refresher training in relation to responding to incidents, suspicions or allegations of abuse. The person in charge said that staff were due to have this training updated. Residents with whom the inspector spoke with confirmed that they felt safe in the centre and that they knew who to talk to if they

needed to report any concerns. There was a nominated person to manage any incidents, allegations or suspicions of abuse.

The person in charge informed the inspector that there were no residents who displayed behaviour that challenged. There was a policy on dementia care which incorporated aspects of behaviours that challenge. The staff nurse told the inspector that there was good access to mental health services within the area. Training in the management of challenging behaviour had been provided for staff in 2013 therefore staff required further up-to-date training.

There was no policy available on restraint but the person in charge said the practice in the centre was one of a restraint free environment The inspector saw that restraint was not common place in the centre and none were in use on this inspection.

The financial controls in place to ensure the safeguarding of residents' finances were discussed with the person in charge. There was a policy outlining procedures to guide staff on the management of residents' personal property and possessions dated February 2016. Residents manage their own finances. Each resident had their own personal lockable storage in their bedroom for same.

Judgment:

Non Compliant - Moderate

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:

There was a risk management policy and a risk register in place. However, it did not meet the regulatory requirements as it did not have the measures in place to control the following specified risks:

- accidental injury to residents, visitors or staff
- self harm

There was an emergency plan formulated in relation to fire, all emergency situations and where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, continence, nutrition, moving and handling. There was safety statement place dated August 2015. The inspector observed that the health and safety policies, risk management and emergency plan did not have an implementation

or review date which would ensure up to date and high quality evidence based accurate information.

Fire safety measures were in place. A procedure for the safe evacuation of residents in the event of fire was displayed and all fire detecting equipment had been recently serviced. Training records viewed confirmed that staff had received formal fire safety training and there was an on going training plan in place. There was an effective programme in place for the servicing fire fighting equipment and checking of all fire doors.

Staff spoken with were familiar with the centre's procedures on fire evacuation. Fire drills took place at least every six months and all staff were facilitated to attend. Residents also participated in the unannounced fire drills the last one took place on 3 June 2016. Records of daily, weekly and monthly fire checks were made available to the inspector. These checks included inspection of the fire doors, fire extinguishers, escape routes, fire panel and emergency lighting.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents. The PEEPs were detailed and outlined any mobility, visual, cognitive and auditory impairments of each resident and the supports required for evacuation. The PEEPs were updated on 19 July 2016 by nursing staff to reflect any changes in a resident's condition. A summary of the PEEPs had also been developed to serve as a quick reference guide for staff.

Training in moving and handling of residents was facilitated for staff. Staff were due refresher training in November 2016. Residents were promoted to maintain their independence when mobilising. The inspector observed that residents did not have routine manual handling requirements.

Infection control practices were guided by a centre-specific policy. As on the previous inspection the policy did not contain a review or implementation date. Hand washing and sanitising facilities were readily accessible to residents, staff and visitors. Designated hand washing facilities was provided in the laundry.

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:

Medicines for residents were supplied by a local community pharmacy. There was evidence that the pharmacist was facilitated to meet her obligations to residents, including medication reviews and resident counselling.

Medicines were stored securely. A designated refrigerator was available to store medicines that required refrigeration. The person in charge said that the temperature was recorded daily when the refrigerator was in use. However, records to confirm this could not be retrieved on the day of inspection. Staff confirmed that controlled drugs were not stored in the centre at the time of the inspection but procedures were in place for storage and documentation in line with current guidelines and legislation.

There was a system in place to ensure that all medications were reviewed on a regular basis by a General Practitioner (GP). Medication administration sheets contained required information and were completed in line with professional guidelines. The medication administration recording sheets reviewed were legible and distinguished between PRN (as needed), regular and short term medication. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications.

The person in charge told the inspector that a medication management audit had been recently completed. However, these records could not be found on the day of inspection. Therefore there was no evidence if any deficiencies had been identified and/or actions had been implemented. Medication management training had been provided by the pharmacist in February 2015.

A staff member outlined the manner in which medicines which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

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):

No actions were required from the previous inspection.

Findings:

Residents had been assessed as not requiring full time nursing care. A nurse was employed who attends the centre for 10 hours per week over two days. Additional care hours could be made available as required, for example if a resident was receiving palliative care. The nurse informed the inspector that she was always available by phone.

There was evidence that timely access to health care services was facilitated for all residents. A number of GPs were attending to the needs of the residents and an "out of hours" GP service was available if required. The records confirmed that residents were assisted to achieve and maintain the best possible health through quarterly medication review, blood profiling if required and annual administration of the influenza vaccine. Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had on going access to allied healthcare professionals including dietetics, speech and language therapy, diabetic clinic, chiropody and physiotherapy.

The inspector reviewed a selection of care plans. There was evidence of a pre-assessment undertaken by the nurse and a member of care staff prior to admission for residents. After admission, there was a documented comprehensive assessment of all activities of daily living, including communication, social care needs, mobility, elimination, personal hygiene, nutrition and sleep. This assessment was reviewed and updated at least every four months or in line with a resident's changing condition.

There was evidence of a range of assessment tools being used and on going monthly monitoring of nutritional need, falls and pressure sore risk. Each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances and was reviewed no less frequently than at monthly intervals. However, there was no documentary evidence of consultation with residents in the development and review of care plans even though the staff nurse told the inspector that she did discuss the care plan with the resident.

Wound management was seen to be in line with national best practice. Wound management charts were used to describe the cleansing routine, emollients, dressings used and frequency of dressings. Wounds were examined on a regular basis. The dimensions of the wound were documented and photographs were used to evaluate the wound on an on going basis.

There was a strategy in place to prevent falls whilst also promoting residents' independence. An evidence-based assessment tool was used to assess residents' risk of falls on admission and at least every monthly thereafter. A falls checklist was used to guide staff in preventing falls by completing regular environmental checks and ensuring that resident has access to the required mobility and sensory aids.

Residents' social care needs were met and residents had opportunities to participate in meaningful activities, appropriate to their interests and preferences. A social care plan was developed for each resident on admission and updated monthly. The social care

plan outlines residents' social contacts and the hobbies and activities they enjoy.

There was a range of activities offered including gentle exercise, arts and crafts, matinee afternoon, bingo and live music. Residents were facilitated to attend activities external to the centre. Day trips out were organised to the local garden centre or shopping. Residents enjoyed going to the local town to meet friends and to socialise.

Judgment:

Substantially Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

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

Findings:

The centre was a purpose built two-storey building located within a development which also contains eight independent houses or 'chalets'. Resident accommodation was provided on the ground floor and staff facilities were provided on the first floor. The entrance was wheelchair accessible and led to the main reception area. The manager's office and treatment room are located close to the main reception area. Communal accommodation consisted of a large multi-purpose room which was used for sitting, recreation and dining and there was clear distinction of functions. There was adequate dining space to accommodate all residents comfortably. A small quiet room, an oratory and a smoking room were also provided.

Residents were accommodated in twelve single bedrooms; none of these rooms were en-suite. Each bedroom provided a wash hand basin and adequate storage for personal possessions including a lockable storage space. Four toilets, one bathroom with assisted shower, non-assisted bath, wash-hand basin and toilet. Another assisted shower room with shower, wash-hand basin and toilet are also provided for residents' use.

Ample parking is provided to the front of the centre and there was ample outdoor space provided within the development. Seating was provided and the grounds were seen to be kept safe and attractive with mature planting. Circulation areas, toilet facilities and shower/bathrooms were adequately equipped with hand-rails and grab rails. Emergency call facilities were in place.

On the previous inspection it was found that renovations were underway to provide an adequate sluice area with the major building and electrical work completed. The provider nominee and the person in charge outlined that the next stage was to secure funding to purchase equipment and fundraising was underway with the sluice room and torn flooring in the laundry area to be completed by September 2015. The inspector observed that these actions remain outstanding. The sluice room was not finished as equipment had not been installed nor had the floor covering been replaced.

Judgment:

Non Compliant - Moderate

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:

There was a planned and actual staff roster in place which showed the staff on duty during the day and night and was properly maintained. Based on observations, a review of the roster and these inspection findings, the inspector was satisfied that the staff numbers, qualifications and skill-mix were appropriate to meeting the number and assessed needs of the residents. The inspector observed that residents were familiar with staff.

Residents spoke positively about staff and indicated that staff was caring, responsive to their needs, and treated them with respect and dignity. There was evidence of some communication amongst staff with sporadic staff meetings taking place. The inspector observed that the most recent staff meeting one had taken place in March 2015. The inspector saw that staff had available to them copies of the Regulations and the Standards.

Staff training records did not demonstrate a proactive commitment to the on going maintenance and development of staff knowledge and competencies. Further education and training completed by staff this year to date was dysphasia training which had been

completed in June 2016. As outlined under Outcome 7 mandatory training in relation to elder abuse was not up to date.

Staff were supervised appropriate to their role through an informal process. However, as agreed on the previous inspection a formalised and documented system of supervision and appraisal was required to be implemented to ensure that supervision improved practice and accountability. This had not commenced even though in the response to the previous action plan the person in charge stated that it would be completed by December 2015.

As outlined under Outcome 5 in a sample of four files reviewed by the inspector there was no photographic identification available in one file and references were missing in another file as observed by the inspector. The person in charge told the inspector that there were volunteers working in the service at the time of inspection. However, there were no vetting disclosures provided and their role and responsibilities were not set out in a written agreement appropriate to their level of involvement in the centre.

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:

Ide Cronin
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:	Gahan House
Centre ID:	OSV-0000545
Date of inspection:	11/08/2016
Date of response:	31/08/2016

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:

It was not demonstrated that there was a clear commitment by the management team to promote and strengthen a culture of quality and safety.

1. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and

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

details responsibilities for all areas of service provision.

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

It is our policy to operate a quality management system to facilitate improvement to the quality of service and the quality of care at the home. All staff will be made aware of this policy and will be encouraged to contribute to the data used for learning purposes. Management understand that mistakes will be made and the QMS will employ these mistakes to carry out improvement in the home. Residents, relatives and staff are invited to contribute to the QMS through the complaint system.

Proposed Timescale: 30/10/2016

Theme:

Governance, Leadership and Management

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

There were no audits available on the day of inspection. Ensure that there is an established system of auditing put in place to elicit any deficits within the service and disseminate feedback which would promote learning.

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:

A new Quality Management System is being installed.

The QMS is based on a system of problem identification and the taking of corrective action, based on the learned outcome from the problem and for the purpose of continuous improvement. The home will conduct regular audits, collect and review adverse data and all of this is managed in the quality management system. There is a structured quality improvement programme now in place to address any deficits, which facilitates appropriate action.

Proposed Timescale: 30/10/2016

Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of care delivered to residents had not taken place for 2015 as required by the Regulations.

3. 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:

Going forward we will ensure that there is an annual review of the quality and safety of care delivered to residents, to ensure that the care given is in accordance with National Quality Standards for Residential Care Settings for Older People in Ireland and in accordance with the homes own policies and procedures. Where appropriate and possible the review is prepared with the help of the residents and their families and is available to both residents and the Chief Inspector if it is requested.

The review will be carried out as follows:

Data collected which includes the weekly collection of data, monthly audits, annual audits, external audits and reports, complaints, incidents, risks, medication errors and surveys will be reviewed at the end of the annual period and the following data will be extracted:

- 1.The number of occurrences of the adverse event/non conformance
- 2.the RCA carried out
- 3.the action(s) taken or proposed to resolve the problem/non conformance
- 4.the results of the actions taken and if the problem has been eliminated or if not the action to be taken in a reiteration process.
- 5.the learning / continuous improvement.
- 6.Pplans to reduce the problem in the coming annual review period.

The annual review for 2015 will only include a summary of the data available from the audits and residents surveys .

Proposed Timescale: 03/10/2016

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The Residents' Guide did not contain the following information:

- terms and conditions relating to residence in the centre.

4. Action Required:

Under Regulation 20(2)(a) you are required to: Prepare a guide in respect of the designated centre which includes a summary of the services and facilities in the centre.

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

The Residents' Guide will be amended to contain the following information:

- terms and conditions relating to residence in the centre.

Proposed Timescale: 19/09/2016

Theme:

Governance, Leadership and Management

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

The Residents' Guide did not contain the following information:

- Procedure respecting complaints.

5. Action Required:

Under Regulation 20(2)(c) you are required to: Prepare a guide in respect of the designated centre which includes the procedure respecting complaints.

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

The Residents' Guide will be amended to ensure it contains the following information:

- Procedure respecting complaints.

Proposed Timescale: 19/09/2016

Theme:

Governance, Leadership and Management

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

The Residents' Guide did not contain the following information:

- arrangements for visits

6. Action Required:

Under Regulation 20(2)(d) you are required to: Prepare a guide in respect of the designated centre which includes the arrangements for visits.

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

The Residents' Guide will be amended to ensure it contains the following information:

- arrangements for visits

Proposed Timescale: 19/09/2016

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:

There was no policy on communication or creation, access to destruction and retention of records.

7. Action Required:

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

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

All Schedule 5 are been reviewed and updated.

Proposed Timescale: 30/10/2016

Theme:

Governance, Leadership and Management

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

A number of policies listed in Schedule 5 did not contain implementation/review dates and therefore it was not clear if these policies had been reviewed in the previous three years.

8. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

All Schedule 5 are been reviewed and updated and will contain implementation/review dates.

Proposed Timescale: 30/10/2016

Theme:

Governance, Leadership and Management

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

In a sample of four staff files reviewed by the inspector there was no photographic identification in a file and in another file there were no references present as required

by the Regulations.

9. 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:

We will ensure that the records set out in Schedules 2, are kept in the home and are available for inspection by the Chief Inspector. A complete audit of all staff files will be undertaken.

Proposed Timescale: 30/10/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Training in the management of challenging behaviour had been provided for staff in 2013 therefore staff required further up-to-date training.

10. Action Required:

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

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

All staff will be trained in the management of challenging behaviour.

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 no policy on restraint available.

11. Action Required:

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

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

A new policy on restraint has been developed.

Proposed Timescale: 30/10/2016

Theme:

Safe care and support

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

It was difficult to ascertain from training records reviewed whether or not staff had received refresher training in relation to responding to incidents, suspicions or allegations of abuse.

12. Action Required:

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

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

A training matrix will be available .All staff will have refresher training in relation to responding to incidents, suspicions or allegations of abuse.

Proposed Timescale: 31/12/2016

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 risk management policy did not meet the requirements of legislation as it did not have the measures in place to control the following specified risks:

- accidental injury to residents, visitors or staff
- self harm

13. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

The risk management policy has been updated and now meets the requirements of legislation as it now has the measures in place to control the following specified risks:

- accidental injury to residents, visitors or staff
- self harm

Proposed Timescale: 30/09/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

There was no documentary evidence of consultation with residents in the development and review of care plans.

14. Action Required:

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

Each problem identified during assessment shall be used to create an individual care plan.

Within each Care Plan, the following shall be determined:

- Description of Problem
- goal of Care
- nursing Intervention Required to Achieve Goal (This shall contain a number of steps which shall be individually numbered)
- date for Re-assessment of Care Plan
- date and time of Care plan creation
- signature of Staff Member and Resident where possible.

Each resident is consulted with, and participates in, the development of their individual care plan with the multidisciplinary team.

Proposed Timescale: 30/11/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The floor covering in the laundry area had not been replaced.

15. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in

accordance with the statement of purpose prepared under Regulation 3.

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

The floor covering in the laundry area is been replaced.

Proposed Timescale: 30/10/2016

Theme:

Effective care and support

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

The equipment in the sluice room had not been installed.

16. Action Required:

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

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

The equipment in the sluice room will be installed .

Proposed Timescale: 30/10/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Staff training records did not demonstrate a proactive commitment to the on going maintenance and development of staff knowledge and competencies.

17. Action Required:

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

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

- Competencies are examined during the appraisal (Appraisal Chart 79) process where gaps are identified and where training is required to close the gaps.
- A training matrix Chart 44 is maintained. The matrix identifies all training which has been completed and all training required in the defined period. Training requirements are identified based on statutory requirements, local requirements, specialist care and take into account the assessed needs of the resident.

Proposed Timescale: 31/12/2016

Theme:
Workforce

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

Put in place a formalised and documented system of supervision and appraisal to ensure that supervision improves practice and accountability.

18. 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:

All Staff are provided with job descriptions, orientation training, ongoing training and support from supervisors and an annual review which identifies any gaps. A formal appraisal of all staff will take place on an annual basis by their supervisor. The PIC supervises all staff. In the course of this supervision she will record the event in the supervision log it can involve more than one person at a time.

The PIC/ Provider supervise all ancillary staff. The supervision log will be used in the same way.

Proposed Timescale: 31/12/2016

Theme:
Workforce

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

Roles and responsibilities of volunteers were not set out in a written agreement appropriate to their level of involvement in the centre.

19. Action Required:

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

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

Volunteers' roles and responsibilities shall be set out in a written agreement between the home and the individual which is signed by both parties. This shall include specific detail of the nature of the work required and the frequency of the service.

Volunteer's roles are set out in Chart 84 which is completed by the PIC/Provider as appropriate.

Proposed Timescale: 30/11/2016

Theme:
Workforce

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

There were no vetting disclosures provided for volunteers.

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:

All volunteers will provide confirmation of identity and Garda clearance, and verification of all qualifications.

Proposed Timescale: 30/11/2016