

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Brendan's Community Nursing Unit
Centre ID:	OSV-0000633
Centre address:	Lake Road, Loughrea, Galway.
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Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Siobhan O'Sullivan
Lead inspector:	Marie Matthews
Support inspector(s):	Mary McCann
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	97
Number of vacancies on the date of inspection:	3

About Dementia Care Thematic Inspections

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
30 March 2016 10:30	30 March 2016 19:30
31 March 2016 09:00	31 March 2016 17:30

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

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

Summary of findings from this inspection

This report sets out the findings of an unannounced thematic inspection. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection focused on six specific outcomes relevant to dementia care.

Prior to this inspection the provider had submitted a completed self- assessment document to the Authority along with relevant policies. The inspectors reviewed these documents prior to the inspection.

As outlined in the Statement of Purpose the centre provides care for residents requiring long term admission, convalescent or a respite service. Residents with dementia were included in each category. The centre is registered to accommodate

97 residents and was at full occupancy on the day of inspection. Two residents were in hospital. The centre is laid out on two floors and in four units known as Crannóg, Coreen, Knock Ashe and Sliabh Aughty. Each care area can accommodate twenty five residents and a lift is available to allow residents to move easily between floors. Coreen is the dementia specific unit and there were 24 residents with a formal diagnosis of dementia accommodated in this unit. A further 14 residents with some cognitive impairment were accommodated in the other units.

Inspectors met with residents, relatives, staff members and the person in charge and tracked the journey of residents with dementia. They observed care practices and interactions between staff and residents. They used a formal observation recording tool for this and found evidence of positive and connected care by staff. They also reviewed documentation such as care plans, medical records and staff files. Residents' healthcare needs were generally met and doctors visited regularly. There was timely access to most allied health professionals but poor access to physiotherapy therapy services and some residents waiting on access to dietetics services.

The design of the centre allowed for the movement of residents with ample corridors on each unit giving freedom to walk around but there wasn't an enclosed accessible garden that residents could independently access outside the centre. All communal areas were not in regular use to ease congestion.

A total of six Outcomes were inspected. The inspector judged 2 Outcomes as substantially compliant and four outcomes were judged to be moderately non-complaint with the Regulations.

Inspectors identified that improvements were required to ensure care plans provided sufficient detail to guide care and to reflect the residents' changing needs. Improvements were also identified in the way that staff were deployed to ensure staff were available at times when resident needed them particularly in the evening and at night.

The Action Plan at the end of this report the areas where improvements are required to comply 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.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

This outcome relates to assessment and care planning, access to healthcare, medication management, nutritional care and also encompasses end of life care.

There was one action under this outcome post the last inspection. This related to provision of safe management of epilepsy care plans. This action had been addressed.

The self assessment tool (SAT) completed by the provider was rated compliant for this outcome. Inspectors followed the pathway of residents with dementia and tracked the journey from referral, to admission, to living in the centre.

No evidence was available on most residents' files reviewed of pre admission assessments. Staff explained to the inspectors that the person in charge or her deputy attended pre admission meetings. There was evidence of communication with family members and the referring agency/person in some files reviewed. An admission policy was available. On review of residents' care files inspectors found that while their hospital discharge documentation was available most files of residents admitted under 'Fair deal' did not include a copy of the Common Summary Assessments (CSARS) which details the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment.

Systems were in place to prevent unnecessary hospital admissions. Staff had been trained in sub-cutaneous fluid administration and administration of intravenous antibiotics and the centre described good links with the palliative care team. A palliative care suite was available. There were no residents who had pressure wounds on the day of inspection.

Inspectors found that the quality of care plans varied between the four different units. Comprehensive assessments and a range of additional risk assessments had been carried out for the majority of residents and staff had developed care plans for some residents based on the risks and care needs identified. However, some care plans reviewed lacked sufficient detail, for example, a care plan with regard to diabetes failed to detail how often to complete blood sugar levels or details re hypoglycaemia or

hyperglycaemia. Care plans were not linked to the assessments, for example, on some falls prevention care plans there was no indication whether the resident was at low, medium or high risk of falling. Some residents had a falls prevention care plan and a mobility and safety care plan. However, on one reviewed, these were contradictory with one stating the resident used a Zimmer frame to assist with walking; the other stated the resident mobilised with two walking sticks every day.

While staff informed the inspectors that they evaluated care plans on a four monthly basis, inspectors found the evaluation failed to ensure the care plan was revised to reflect the residents' changing needs and some care plans were not reviewed at four monthly intervals. For example, some care plans were longer than six months without an evaluation. There was poor evidence available that residents and/or family, where appropriate, participated in reviews of the care plans. Some care plans had been discontinued but remained in the case files and it was difficult to distinguish if these were in operation. For example, a resident had a care plan for a skin tear in her case file which had been discontinued in May 2015.

A pain assessment tool in place and while some residents who were administered analgesia had a pain assessment completed, this assessment was not recent, some were dated 2014. On one care plan reviewed it stated that staff would monitor the effectiveness of the analgesia administered at regular intervals, however this was not occurring and there was poor evidence available that a procedure was in place for monitoring the effectiveness of analgesia administered.

Improvement was required to the management of residents' nutritional needs. Most residents were screened for nutritional risk on admission and this was reviewed regularly thereafter. However, on one residents' file that was a recent admission, inspectors noted that a very low admission weight had been recorded. No nutritional assessment had been completed. When one of the inspectors discussed this with the staff they stated this was an error, however, there was no response in the care documentation to these findings. While this resident had been seen by speech and language therapy services and the general practitioner he had not been seen by the dietician. Staff had referred him by phone to the dietician but when one of the inspectors met the dietician she stated that referrals were only accepted in a written format. Additionally, there was no nutritional care plan or food and fluid chart to ensure he was receiving appropriate nutritional intake. Staff reported that the resident was eating well and had gained weight since admission. Another resident who was identified by staff as being nutritionally compromised did not have a food and fluid intake chart or a detailed specific nutritional care plan. While the care plan stated that breakfast was their favourite meal there was no detail as to what the resident liked to eat for breakfast or whether the food offered was to be fortified.

Other care plans with regard to nutritional care were not linked to the nutritional assessment, failed to identify how often the resident should be weighed and did not detail if the resident was on a fortified diet or what supplements the resident was prescribed. While staff informed the inspectors that residents were being weighed monthly and their weights were recorded, this was not always occurring. Staff recorded the weight of a resident on three different forms. On reviewing this inspectors noted on reviewing one residents care file he was weighted nine times in fifteen months.

Inspectors observed residents having their lunch in the dining rooms. Adequate staff were available to assist and monitor intake at meal times. Some residents choose to dine in their own bedrooms, and this was facilitated. A list of residents on special diets including diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids was available to catering and care staff. One of the inspectors met with the chef, he displayed a good knowledge of the specific nutritional needs of residents. Residents confirmed that they enjoyed the food. The inspector noted that meals were hot and well presented. The kitchen was open 24hrs per day and snacks were freely available. The inspector saw residents being offered drinks throughout the day. Residents told the inspector that they could have tea or coffee and snacks any time they asked for them.

Residents did not have timely access to all allied health professionals. Inspectors noted that there was poor input from physiotherapy therapy services on some care files including residents who had several falls recorded. For example, one man had fallen nine times between the 15 May 2015 and 21 December 2015 and the only evidence available in the care file was that he had been seen by the physiotherapist was for 2014. This was clarified with staff who stated that they had no record that he had been seen more recently. One resident spoken with by the inspectors told them he would value more physiotherapy input. A physiotherapist was allocated to the centre for 2.5 days per week , but staff informed the inspectors that she worked also in the day centre and with residents who were accommodated rehabilitative care beds. There was access to other peripatetic services such as dietician, chiropody and speech and language therapy (SALT) services. Two occupational therapists worked in the centre. They took the lead on activity provision in addition to offering an occupational therapy service.

Residents had access to the psychiatry of later life team who visited the centre as required. There was also good access to General Practitioners (GPs); however residents were not facilitated to keep their own General Practitioner on admission to the centre. A system was in place to ensure that residents with glasses had their eyesight tested on an annual basis. Dental referrals were actioned as required.

Arrangements were in place to review accidents and incidents. Residents at risk of falling were assessed using a validated falls assessment tool. However, falls prevention care plan required review to ensure they provided guidance to staff in the delivery of safe care and to mitigate the risk of further falls for the resident. Evidence was available that post-fall observations including neurological observations were undertaken to monitor neurological function after a possible head injury as a result of a fall.

Inspectors examined the files of residents who were transferred to hospital from the centre. There was limited records of communication between the centre and acute care services when a resident was being transferred for care. Staff informed the inspectors that they forwarded a letter to the hospital but no copies of these were kept in the centre. Additionally there was no narrative note maintained to indicate that this occurred. Discharge summaries from the acute hospital and letters post consultations with medical staff in the acute hospital were available on files reviewed.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Findings:

Residents whom the inspectors spoke to said they felt safe and secure in the centre, and felt the staff were supportive. Relatives spoken with felt their next of kin was being supported and receiving safe care. There were procedures in place for the prevention, detection and response to abuse which had been reviewed since the last inspection. The policy was supplemented by additional information to reflect the new Health Service Executive (HSE) policy on Protection of Vulnerable Adults but didn't identify who the designated person was for the centre or include details of the Confidential Recipient. Staff spoken with were able to explain the different types of abuse, signs to look out for and how to report any concerns. Staff identified the person in charge as the person to whom they would report a suspected concern. Inspectors viewed records confirming there was an ongoing program of refresher training in protection of vulnerable adults.

The person in charge stated that the centre was aiming to promote a restraint free environment. Signed consent was obtained by the resident or their representative and the GP before a restraint, usually a bedrail, was put in place. Risk assessments for the use of restraint were carried out and reviewed regularly by staff but they did not demonstrate that alternative options had been fully explored prior to use of the bedrail. Inspectors also observed that care plans were not developed to guide the care of residents who used a bedrail. There were 13 residents who used bedrails as an enabler. Inspectors were told that these were in place for the purpose of positioning or enhancing resident function. However, there was no explanation recorded in the care plan other than 'as enabler'.

Some residents had behaviours and psychological symptoms of dementia (BPSD). There was a policy in place for behaviour that is challenging, and staff had received training on understanding and managing behaviours that challenge. Staff spoken to by the inspectors were knowledgeable regarding interventions that were effective in managing such behaviours including redirection and engaging with the residents. There was evidence in care plans of links with the mental health services. Behaviours logs were being completed to identify triggers and to inform further planned reviews by the psychiatry team and behavioural support plans reviewed had proactive and reactive strategies to direct care in a consistent manner.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

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

Findings:

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with a dementia. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2(positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place at different times for intervals of 15-30 minutes in sitting and dining areas of each unit and observations were undertaken both in the morning and afternoon. The inspectors concluded at the end of the observation periods that most of the residents experienced positive connective care. An activity programme was in place which included group activities such as cards and bingo, exercise programmes and music sessions but there were individual therapeutic activities provided to residents who chose not to take part in group activities. There were 9 residents in bed on the afternoon of the inspection and a one to one activities were delivered to these residents in their bedroom which comprised of included hand massage, reminiscence therapy and relaxation sessions. Reminiscent videos were used in the evenings to stimulate conversation among residents. Clocks and calendars displayed in communal areas to help orientate residents.

Bedrooms and bathrooms had privacy locks in place. A sitting room know as the parlour was available on the ground floor which had tea and coffee making facilities and inspectors observed this room was in use by residents and relatives throughout the inspection. Newspapers, televisions, radios and internet access were available. A phone was available for residents to make or receive phone calls in private. Large screen televisions were provided in each unit. Residents were facilitated to vote in the centre in the recent election. A retired staff member had completed advocacy training and worked as an advocate to residents and chaired the resident committee meetings which were held every three months.

Residents' capacity to make decisions and give consent is described in care plans. Inspectors observed that staff sought consent from residents prior to entering their bedrooms and residents privacy was respected during personal care which took place in the residents own en suite bedroom. There were no restrictions on visitors and residents could receive visitors in private.

Residents with good cognitive ability choose what they liked to wear and inspectors saw residents looking well dressed. Their described a choice at mealtimes. Residents

appeared comfortable with staff, engaged with them and looked for them when they needed support. Staff knew residents well and could describe for inspectors their backgrounds and specialist interests.

Residents told inspectors that they could chose the times they wanted to get up in the morning, and whether they wanted to take part in scheduled activities. However, as discussed under outcome 5, the manner in which the staff were deployed in the evening and at night meant that any residents who required the assistance of two staff to go to bed had to retire before 5.30 which impacted on the some residents right to choose the time at which they retired at night. An action has been included under outcome 5 requiring the provider to address this.

Judgment:

Substantially Compliant

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The complaints procedure was on display in the foyer as visitors entered the building. The centre had its own complaints procedure leaflet which gave an outline of the complaints procedure included a space to record a complaint. Residents spoken with said that they knew how to make a complaint and identified the person in charge or any of the staff as people they could complain to.

The complaints policy available met the requirements of the Regulations. It was also available in an accessible format in the centres' residents' guide. A review of the complaints log indicated that there were few complaints recorded and most were dealt with within a suitable timeframe. The outcome of the complaint and if the matter was resolved to the satisfaction of the complainant was recorded. The inspectors found that a small number of complaints had not been closed off and there was no indication recorded of the actions taken in response to the complaint. It was not possible in these recorded complaints to determine if the complainant was satisfied with the outcome. Residents had access to an independent advocate who chaired the residents meetings.

Judgment:

Substantially Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

From reviewing staff rosters inspectors saw that there was a staff nurse on duty in each unit at all times. There were in total forty nurses and fifty eight health care assistants employed to care for residents. The person in charge told the inspector that staffing levels and skill mix were based on the assessed needs and dependency levels of residents and were reviewed on a daily basis. However, adequate availability and deployment of staff to ensure that residents needs were consistently met throughout the day and night was not evident on inspection.

The rota indicated that staffing levels reduced by over 50% in the evening and there was no clear rationale for this reduction. In addition to the Person in Charge and the Assistant Director of Nursing, there was four health care assistants and 3 nurses on duty in each unit in the morning and during the day. This reduced to two nurses and one care assistant from 5.30 to 20.00 and after 20.00 staffing levels reduced to one nurse and one care assistant. The nurse completed a medication round every night which meant that there was only one care staff available to supervise residents and assist them to bed. Consequently, inspectors observed that a high number of residents were in bed by 5.30 in the evening. An additional nurse came on duty from 20.00 to 08.00 and covered the 4 units. Inspectors were told that this staff member helped to relieve staff for breaks and looked after any residents who were unwell. The inspectors also saw that the PIC was not included in the staff rota and working times were not recorded using a 24 hour clock. Codes were used to denote work shifts, for example EE denoted a 9.75 hour shift but the key did not state the starting or finishing time for this shift.

Training records were reviewed and evidenced that all staff had been provided with required mandatory training such as fire safety, moving and handling and adult protection. Training in areas such as dementia care, nutrition; consent and capacity; management of behaviour that challenges and medication management was provided on an ongoing basis. There was evidence on yearly staff performance appraisals in the personnel files reviewed.

In the staff files reviewed all the requirements of Schedule 2 of the Regulations were available including Garda Vetting and appropriate references. The registration numbers for nursing staff with an Bord Altranais agus Cnáimhseachais na hÉireann were available on staff files.

Judgment:

Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

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

Findings:

The inspector were satisfied that the premises met with the requirements of the Regulations and the Authority's Standards. There were four care areas, two were located on the ground floor either side of the main reception and two were on the first floor. The care areas are called Crannóg, Coreen, Knock Ashe and Sliabh Aughty. Residents with dementia were mainly accommodated in Coreen on the ground floor. Each area provided views overlooking Loughrea Lake. The four units were clean and bright and offered residents a choice of communal areas. There was a visitor's room, a smoking room and a dining room in each unit. Seating was also provided in the hallway. Furnishings were comfortable and homely.

Better use of communal areas was discussed with the PIC to ensure a more comfortable space for residents which was free from obstructions and easier to navigate. Although there were two communal areas available in each unit, only one was observed to in use by most residents and this was very congested.

There were twenty one single bedrooms and two double rooms in each of the four care areas. Each resident's room was identified by their name or a picture reference. There were various other visual cues to aid recognition and help orientate residents. Each single bedroom had an en suite assisted shower and toilet facility which could be seen from the residents' bed. Resident's were encouraged to personalise their rooms with photographs and personal belongings. There were separate assisted bathrooms on each floor.

There was a nurse's station in each area. Hand rails were provided in all circulation areas and corridors were wide and spacious to accommodate residents using walking assistive devices or wheelchairs. Hand painted pictures decorated corridors. The sluice rooms and rooms where chemicals were stored were protected by a swipe card system to prevent residents from accessing them for example.

The grounds of the premises were landscaped since the last inspection and were well maintained. Residents had supervised access to a paved area to the rear of the centre however as the building was built on a sloped site, there was no level accessible enclosed garden space residents could access independently.

Blinds were used to block the sun in the main day rooms on the first floor but the room was still very warm. This issue was identified on the previous inspection and a fan was acquired but this was not in use at the time of inspection.

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:	St Brendan's Community Nursing Unit
Centre ID:	OSV-0000633
Date of inspection:	30/03/2016
Date of response:	17/06/2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

There was no evidence on most residents' files reviewed of pre admission assessments. A copy of the Common Summary Assessments (CSARS) which details the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment was not available for residents admitted under the Fair Deal scheme.

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

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

- All residents are assessed by an appropriate health care professional prior to admission to the unit, as part of the admission procedure the information is relayed to the staff in the admitting care area in the form of Doctors letter, prescription, nursing transfer letter hospital discharge letter, admission referral forms and assessment by the PIC. Immediately prior to admission this information is updated and verified.
- In addition to the process to date the PIC will arrange for a copy of the Common Summary Assessment Form to be obtained and placed in the resident's files.

Proposed Timescale: 01/06/2016

Theme:

Safe care and support

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

Care plans were not linked to the assessments. For example, on some falls prevention care plans there was no indication whether the resident was a low, medium or high risk of falling.

2. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

- An audit of care plans has been carried out.
- Where care plans are identified as not linked to assessments the care plans are updated to reflect a link between the assessment and the care plan.
- Nursing Staff have attended refresher training on care planning.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

some care plans were not reviewed at four monthly intervals or when there was a change in the residents assessed needs and some care remained in the case files despite been discontinued.

3. 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:

- An audit of care plans has been carried out.
- Where care plans are identified as not having been reviewed at four monthly intervals or when there was a change in the residents condition these care plans are now updated.
- Nursing Staff have attended refresher training on care planning.
- Discontinued care plans to be filed in chart.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

There was poor evidence available the effectiveness of analgesia administered was being monitored.

One residents with very low admission weight did not have a nutritional assessment been completed. and had not been seen by the dietician. There was no nutritional care plan or food and fluid chart to ensure he was receiving appropriate nutritional intake. .

4. Action Required:

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

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

- Analgesia Pain Charts in place to assess resident post administration of PRN analgesia.
- Care plan development is part of admission process for each resident, following assessment using assessment tools, resident will be referred to appropriate discipline & copy of referral kept in residents file. Process will be audited to ensure compliance.

Proposed Timescale: 01/06/2016

Theme:

Safe care and support

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

There was lack of input from physiotherapy therapy services on some care files reviewed, including those of residents who had sustained several falls.

5. Action Required:

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

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

- All residents are assessed on admission by the nursing staff and medical officer, residents who require additional professional expertise are referred to the relevant professionals for assessment and treatment as appropriate.
- All residents admitted to the the unit are assessed on admission by the physiotherapist and occupational therapist. A further referral is forwarded to appropriate professionals on admission or as the condition of the resident changes.
- Copy of referral is kept in residents file.

Proposed Timescale: 01/06/2016

Theme:

Safe care and support

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

Residents were not facilitated to keep their own General Practitioner on admission to the centre.

6. Action Required:

Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

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

- Resident may keep their own GP if that GP is available & agrees to provide medical care to resident.

Proposed Timescale: Refer to factual inaccuracy report

Proposed Timescale:

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

The elder protection policy didn't identify who the designated person was in the centre

or include details of the Confidential Recipient

7. 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:

- The elder protection policy identifies who the designated person is in the centre and includes details of the Confidential Recipient
- A statement to reflect this is located on the wall in the reception area of the unit.

Proposed Timescale: 01/05/2016

Theme:

Safe care and support

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

Restraint practice was not evidence based. Risk assessments for the use of restraint did not demonstrate that alternative less restrictive options had been fully explored. There was no explanation recorded in the care plan as to the enabling function for bedrails in use as enablers.

8. Action Required:

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

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

- All residents with Restraint & Enablers in use will be reassessed.
- A risk assessment for the use of restraint will demonstrate that an alternative less restrictive options has been fully explored. This will be documented in the residents care plan.
- Residents who use enablers will have an explanation recorded in the care plan as to the enabling function where a bedrail is in use as enablers.

Proposed Timescale: 30/06/2016

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Some complaints were not closed off and there was no indication recorded of the actions taken in response to the complaint or if the complainant was satisfied with the outcome.

9. Action Required:

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

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

•All complaints are managed under the complaints procedure a review of the complaints file has occurred and the complaint which was not closed has been closed off.

Proposed Timescale: 01/05/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Staff availability and deployment did not ensure that residents needs were consistently met throughout the day and night.

10. 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:

•PIC will review the current staffing roster. PIC will meet with the staff and management team discuss re-organisation of duty rosters to ensure that the resident's needs are met in the evening and night.

Proposed Timescale: 30/09/2016

Theme:

Workforce

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

The Person in Charge was not included in the staff rota and working times were not recorded using a 24 hour clock.

Codes were used to denote work shifts, for example EE denoted a 9.75 hour shift however the key did not state the starting or finishing time for this shift.

11. 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:

- All roster state the start and finishing time for shift.

Proposed Timescale: 13/06/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

Although there were two communal areas available in each unit, only one was observed to in use by most residents and this was very congested.

12. 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:

- Two communal areas are available in each care area in accordance with regulatory requirements. Residents have a choice of area in which to sit. It is noted that the preferred option of the main communal area is more congested at intervals in the day.
- PIC will meet with staff to discuss this concern.

Proposed Timescale: 16/06/2016

Theme:

Effective care and support

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

There was no level accessible enclosed garden space residents could access independently.

13. 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 unit has three main gardens two of which are enclosed and situated to the front of the unit to maximise the views of the lake. Residents who can mobilise independently have access to these gardens. Residents who require assistance with mobility or who have an unsteady gait are accompanied by staff to the garden areas on a regular basis and often enjoy this space with their visitors.
- PIC will explore options to identify a level garden space.

Proposed Timescale: 30/09/2016