

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	St Catherine's Nursing Home
Centre ID:	OSV-0000429
Centre address:	Bothar Buí, Newcastlewest, Limerick.
Telephone number:	069 61411
Email address:	stephen@scncw.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Newcastle West Nursing Home Limited
Provider Nominee:	Stephen Murphy
Lead inspector:	Caroline Connelly
Support inspector(s):	Mary O'Mahony
Type of inspection	Announced
Number of residents on the date of inspection:	67
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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
08 September 2016 10:45	08 September 2016 19:10
09 September 2016 09:00	09 September 2016 17:00

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

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

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection which took place over two days. The provider applied to renew the registration of the centre which will expire on 04 March 2017. As part of the inspection Inspectors met with residents, relatives, the provider, the person in charge, the assistant director of nursing (ADON) who deputises for the person in charge, a clinical nurse manager,

nurses and staff members. Inspectors observed practices and reviewed all governance, clinical and operational documentation to inform this registration renewal application. Inspectors also followed up on the actions required from the previous inspection.

The provider, person in charge, and ADON displayed some knowledge of the regulatory requirements when interviewed during the inspection and they were found to be committed to providing person-centred care for the residents. However a number of the actions required from previous inspections were not completed and therefore remained non-compliant in a number of outcomes inspected.

A number of completed questionnaires from residents and relatives were received and the inspector spoke with residents during the inspection. The collective feedback from residents and relatives was mostly one of satisfaction with the service and care provided however lack of variety in food and access to the safe outdoor space were identified as key concerns on a number of questionnaires and these will be addressed under the relevant outcomes in the report. Overall, inspectors found that there was evidence of good care practices in meeting the day-to-day needs of residents. Staff were kind and respectful to residents and demonstrated good knowledge of residents and intervention necessary for those with divergent needs.

Inspectors were satisfied that residents had access to the services of a general practitioner (GP) and other healthcare professionals on a regular basis. The centre employed a physiotherapist, a physical therapist and an occupational therapist. There was evidence of choice for residents in their day-to-day living with personal preferences accommodated as requested. A regular routine of daily supervised activities was in place and undertaken by the physiotherapy and occupational therapy team. Independence of residents was promoted and many were observed mobilising freely throughout the centre and in the enclosed garden area.

Inspectors found that a number of actions from the last inspection had not completed when they were followed up on this inspection. Inspectors saw that numerous fire doors were wedged open during both days of inspection throughout the centre including some doors on the corridor which would be required for compartmentalisation. The person in charge and the provider were informed that this required immediate action and the person in charge engaged the services of the fire company to look at putting hold backs attached to the fire alarm system on all doors. Inspectors also identified the need for improvement in the statement of purpose, documentation management, complaint handling, provision of up to date policy and procedures, staff training, staff records, risk assessments, smoking areas, the requirement for an annual review and an effective quality management system. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary 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.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose was a reflection of the centre. It stated its strong ethos of providing a good standard of individualised care which inspectors concluded was accurate. However, the document also pointed at a general laxity towards documentation. The copy of the statement of purpose given to the inspectors on day one was an out of date version. A more updated version was provided to inspectors on the second day of inspection. The updated version provided continued to require review as some of the information as required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 was not contained in the document such as the conditions attached to the centre's registration, the description of bedrooms did not include the extra rooms registered on the previous inspection, it did not contain the organisational structure of the centre and the arrangements for the management of the centre when the person in charge is absent from the centre.

Issues around the accuracy of the statement of purpose have been identified at previous inspections.

Judgment:

Non Compliant - Moderate

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

There was a clearly defined management structure that identified the lines of authority and accountability. The person in charge was supported in his role by a deputy person in charge and a clinical nurse manager. The person in charge reported to the registered providers and board of management. There was evidence of regular visits by the providers to the centre.

However inspectors found the management systems in place were not sufficiently robust to ensure that the service provided was consistent and effectively monitored. This was evidenced by actions not completed from previous inspections, gaps in mandatory training for staff; ineffective systems for management of complaints; no system in place for identifying new or changing hazards; inadequate or missing risk assessments; inconsistent documentation; out of date policies and procedures. There was no evidence of an effective and consistent quality assurance programme in place to continuously review and monitor the quality and safety of care. Although there was some auditing of care plans, pressure ulcers, hand hygiene facilities and medication management these were infrequent and there was not evidence of a quality improvement plan, therefore, in most of the audits it was difficult to assess the level of change which took place. A more systematic approach to auditing practices was needed. On the last inspection the inspectors identified that restraint use, and in particular the use of bed rails was not routinely audited and the centre received an action in relation to this. On this inspection the inspectors saw that although bedrails were now reviewed monthly the audit had not been completed. The inspectors found that overall there was no comprehensive auditing programme established with key performance indicators (KPI's) recorded and no trending of falls, accidents and incidents. There was also no system to ensure an annual review of the service took place as required by the regulations, prepared in consultation with residents and their families and that resulted in a copy (of the review) not being made available to residents and the chief inspector. The person in charge and provider said they were unaware of their requirement to complete an annual review.

Management of documentation was an issue also identified by inspectors on this inspection and on previous inspections. While there was evidence that good care was provided. The frequency in which there were gaps in the record keeping and the lack of a systematic structure around this was not without risk. This aspect of the governance was brought to the attention of the provider and person in charge at previous inspections and it remained an on-going issue. This was also evidenced in that not all the documentation that was prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 was returned to HIQA as required for this application to renew registration of the centre. Following inspection the documentation was resubmitted.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Random samples of resident contracts were reviewed. They were seen to set out the services to be provided and the fees to be charged including what incurred any additional fees such as hairdressing and chiropody. The person in charge said he was going to include a pricelist for these services. Those contracts viewed were dated and signed by the resident and/or their representative and met the legislative requirements.

A Residents' Guide was also available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The nominated person in charge holds a full-time post in the centre, he is a registered nurse, holds current registration with the nursing professional body and has been in charge of the centre for ten years. He has the required experience in the area of nursing of the older person and holds a certificate in health service management.

Residents, relatives and staff were able to identify him as the person in charge and he was engaged in the governance and the operational management and administration of the centre on a regular and consistent basis and this was confirmed by residents and staff.

The engagement of the person in charge with the legislative process could be enhanced by maintaining the required documentation and by engaging in ongoing professional development.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Management of documentation was an issue identified by inspectors on this inspection and on numerous previous inspections. Records keeping in general posed a challenge for the centre and its management staff and there appeared to be a laxity given to the importance of same. Gaps remained in the maintenance of the required documentation. These gaps were seen in the staff files, Inspectors found in two of the staff files reviewed, references were not in place for one new staff and a reference from the last employer was not in place for the other staff member which was outlined further in outcome 18 staffing. As already identified the statement of purpose and function did not meet the requirements of legislation. Schedule 5 policies and procedures given to inspectors for review were out of date, a number were dated 2011 and some March or August 2013 which were not reviewed within the three year period as required by legislation. A number of policies required updating to take account of changing legislation and guidelines such as the safeguarding policy, end of life policies and medication management. Other policies and procedures did not contain enough information to guide practice such as retention of records, emergency procedures and inspectors found all policies required review.

There were gaps seen in the completion of the directory of residents that required action to meet the requirements of legislation.
Such as completion of cause of death, phone numbers and addresses of GP's were missing on a number of records.

Judgment:
Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There had been no instances since the last inspection whereby the person in charge was absent for 28 days or more and the person in charge was aware of the responsibility to notify HIQA of any absence or proposed absence.

Suitable deputising arrangements were in place to cover for the person in charge when he was on leave. The ADON was in charge when the person in charge is on leave. The inspectors met and spoke with the ADON throughout the inspection and she demonstrated an awareness of her responsibilities.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:

A policy was in place for the prevention, detection and response to abuse. However, the policy did not refer to the requirement to notify the Authority of any allegation nor did it clearly outline what to do if an allegation was made against a staff member. The policy was not centre specific and had not been updated since 2013 and did not reference changes to safeguarding legislation and best practice guidelines. This was an action from a previous inspection that had not been addressed. The action for this is under outcome 5 documentation.

Staff with whom inspectors spoke knew what constituted abuse and what to do in the event of an allegation, suspicion or disclosure of abuse. There was no evidence of any barriers to staff or residents disclosing concerns they had in relation to this matter. Residents stated they felt safe and attributed this to the kindness and attentiveness of staff. When there were suspicions of abuse they were appropriately investigated and responded to. Systems were in place to safeguard residents' money and this system was monitored by the person in charge. The centre did not accept any cash handed in for safekeeping. Inspectors reviewed training records and saw that a number of staff had not received safeguarding/prevention of abuse training including a member of staff who had worked in the centre for 18 months. The action for this is under outcome 18 staffing.

There is a policy in place in the centre in relation to the management of responsive behaviour which was not sufficiently detailed and was out of date. The same was found in relation to the restraint policy which was dated 2011. Inspector viewed the use of restraint in the centre and saw that staff continued to promote a reduction in the use of bedrails, there were 11 residents using bed rails at the time of inspection and the inspector saw that alternatives such as low low beds, crash mats and bed alarms were in use for some residents. Inspectors reviewed a sample of files of residents using bedrails and found that risk assessments detailing alternatives tried and considered as well as care plans guiding care were documented. Regular checks of all residents were being completed and documented.

Inspectors observed that residents generally appeared relaxed and content during the inspection. Inspectors reviewed a sample of files of residents presenting with responsive behaviours and noted that comprehensive care plans were in place to guide staff in addition to behavioural support plans. There was evidence that residents who presented with responsive behaviour were reviewed by their GP and referred to psychiatry of old age or other professionals for full review and follow up as required. Inspectors saw evidence of positive behavioural strategies and practices implemented to prevent responsive behaviours. The records of residents who presented with responsive behaviours were reviewed by the inspector who found that these were managed in a very dignified and person-centred way by the staff using effective de-escalation methods as outlined in residents' care plans.

Many staff spoken with confirmed and training records reviewed indicated some staff had attended training on dealing with responsive behaviours. However, training records showed that there were a number of staff that had not received up to date training in responsive behaviours as is required by legislation. the person in charge confirmed further training was booked for November 2016. The action for this is under outcome 18 staffing.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:

There were fire policies and procedures in place. The fire safety plan dated 2014 was viewed by inspectors and found to be comprehensive. However there were not notices for residents and staff on "what to do in the case of a fire" appropriately placed throughout the building. Fire training was provided to staff in 2016 and 2015 and a number of fire drills were conducted however not all staff had received up-to-date fire training. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire and felt that undertaking regular fire drills and training kept their knowledge current. Inspectors examined the fire safety register with details of all services and tests carried out. Fire door exits were unobstructed and fire fighting and safety equipment had been tested in November 2015 and fire alarm test and emergency lighting in August and September 2016. Fire checks were up to date as was servicing of equipment.

Inspectors reviewed the safety statement which was dated 27 March 2014 and the risk management policy which included items set out in the regulations for identified risks. There was a comprehensive record of accidents and incidents. Inspectors found that the centre had the necessary plans and policies in place in relation to risk management and health and safety. However although there was a risk register within the health and safety statement this leaned heavily towards the welfare of staff rather than risks specific to residents, which had been identified as a requirement on previous inspections. These risk assessments and control measures had not been updated since 2014. Inspectors found that not all risks were found to be identified for example, there was no risk assessment for oxygen cylinders stored in an open storage area, two on a trolley for easy access and two separate cylinders stored loosely. gloves were stored on the corridor and in open bathrooms and required risk assessing long strings were seen on blinds in residents bedrooms risk assessments for stairways were not available. there was open access to a storage area on the first floor

Door wedges were routinely used in fire doors which made them ineffective. Inspectors saw that these were used on doors throughout the centre on both days of the inspection

including doors on corridors which should be used for compartmentalisation in the case of fire. The person in charge pointed out that residents did not like the sense of isolation they experienced when the door was closed. The issue in relation to the use of wedges had been identified at a previous inspection. During the inspection the person in charge contacted their fire engineer to commence the process of getting automatic door hold backs that release in the case of fire installed.

A number of residents smoked cigarettes and they used the designated smoking rooms. There was a call bell in the room and it did contain fire fighting equipment including a fire blanket and fire extinguisher. Inspectors were concerned about the safety of residents using the smoking room. While there was a small glass window in the smoking room, due to its location off the corridor there was no visibility for staff and no opportunity to monitor the welfare of residents using the room. The smoking room was not clean with cigarette ash on the floor. The door was open throughout the day and a wedge was seen on the floor. There was an incident completed where a resident fell in the smoking room and did manage to alert staff but inspectors required that the smoking room and visibility and supervision of residents that smoked required urgent review.

Judgment:
Non Compliant - Major

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

Findings:
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, these policies had not been reviewed for over five years. This was identified at the last inspection and remained non compliant on this inspection.
Nursing staff with whom inspectors spoke generally demonstrated good practice regarding administration of medicines. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines and they were checked and counted at the beginning of each shift. The inspector saw evidence of this checking process and the count undertaken by the inspector was found to tally with records in the centre. The medication trolleys were securely maintained and a nurses' signature sheet was in place as described in professional guidelines.

Medications were delivered in monitored dosage units and these were checked by nursing staff to verify that what was delivered corresponded with prescription records. Inspectors reviewed prescription and administration records. The person in charge and staff reported to the inspector that the pharmacist is easily accessible regarding advice relating to drug interactions, dosages, crushing of medicines and possible alternatives in prescriptions and regularly liaised with the relevant GPs regarding prescriptions.

Inspectors reviewed a sample of residents medication charts upstairs and downstairs and identified a number of issues with medication prescriptions that required immediate attention:

Inspectors saw that where crushed medications were required this was not appropriately prescribed in this format for two residents charts viewed.

On another residents chart medications had been transcribed by the pharmacist but was not signed by the GP

Another resident had received antibiotics on a faxed prescription for eight days which was not then signed for in house within 72 hours as required by legislation.

Another resident had a prescription for one extra medication faxed onto her original prescription for as required use on the 23 March 2016 which was not signed for by the GP and never put on the original script but both charts were available which could lead to errors.

Another chart showed an as required night sedation being administered every night but not prescribed on a regular basis.

Nursing staff had continued to administer these medications and these had not been identified or highlighted as errors in fact inspectors were told there were no medication errors in the centre.

Inspectors found there was not a robust system in place for reviewing and monitoring safe medication management practices. Medication audits were conducted by the pharmacist however this was very infrequent, the last audit was conducted in August 2016 and the one previous to that was April 2015 and some of the same issues were identified. There was no evidence to show that corrective actions were taken following from the audit. There is a requirement for nurse managers to carry out audits of medication administration practices, in addition to audits carried out by the pharmacist to ensure safe medication management practices.

Inspectors also found that the storage of prescription creams and nutritional supplements was not sufficiently robust. Inspectors found prescription creams left on lockers and trays of nutritional supplement drinks stored in residents bedrooms under beds and on top of cupboards and lockers. The storage of all prescription items required review.

Judgment:
Non Compliant - Major

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

<p>Theme: Safe care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Inspectors saw that there was a comprehensive log of accidents and incidents that took place in the centre.</p> <p>Incidents as described in the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 have been reported in accordance with the requirements of the legislation. There were timely quarterly returns and written notifications were received within three days of accidents as required.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 11: Health and Social Care Needs</i> <i>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.</i></p>
<p>Theme: Effective care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: Residents' health care needs were met through timely access to medical treatment. A number of general practitioners (GP) attended the centre on a regular basis. Inspectors met and spoke to one of the (GP) during the visit and he expressed satisfaction that his patients received appropriate care in the centre. There was evidence that residents had access to allied health care services. This included the availability of in-house occupational therapy and physiotherapy. These therapies supported the diverse care needs of residents. Where it was identified that residents required specialised seating or specialised equipment this was seen to be arranged for the resident.</p> <p>The care delivered encouraged the prevention and early detection of ill health. For example, residents were enabled to make healthy living choices. Emphasis was placed in ensuring residents meals were nutritious, flue vaccinations were given and residents were seen to be actively encouraged to mobilize in so far as their ability allowed them.</p>

There was evidence of regular nursing assessments using validated tools for issues such as falls risk assessment, dependency level, moving and handling, nutritional assessment and risk of pressure ulcer formation. These assessments were generally repeated on a three-monthly basis or sooner if the residents' condition had required it. Care plans were developed based on the assessments. The ADON, CNM and staff demonstrated an in-depth knowledge of the residents and their physical, social and psychological needs and this was reflected in the comprehensive person-centred care plans available for each resident. Nursing notes were completed on a daily basis.

Residents' additional healthcare needs were met. A chiropody service is provided to the residents on a regular basis in the centre. Dietician and speech and language services were accessed via a nutritional company. Physiotherapy services were provided in-house weekly through group exercises and one to one reviews and treatments. Inspectors saw evidence of referrals and reviews in residents' notes. Inspectors also observed that residents had easy access to other community care based services such as dentists and opticians.

There were very good links with psychiatric services and community services for residents who required these services and assessments and treatment reviews were seen in residents notes.

Inspectors were satisfied that facilities were in place so that each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Residents and relatives said they were satisfied with the healthcare services provided.

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

Findings:
The centre has been in operation as a designated centre for over ten years. Inspectors found that the design and layout of the centre fitted with the aims and objectives of the statement of purpose and the centre's resident profile. It promoted residents'

independence and wellbeing. It is a two story building which contained three lifts one which was large enough to accommodate a bed if required. Residents private accommodation consisted of 49 single bedrooms and nine twin bedrooms with en-suite facilities. There were a sufficient number of other toilets, assisted bathrooms and showers to meet the needs of residents. There was a functioning call bell system in place and there was suitable storage for residents' belongings. Inspectors saw that many bedrooms were much personalised with residents own furniture pictures and belongings. The centre maintained a safe environment for resident mobility with hand-rails in circulation areas and corridors generally kept clean and tidy. There was appropriate heating, lighting and there was a variety of communal space available for residents and relatives use.

The premises and grounds were generally well maintained. A maintenance person was on the staff roster. An organised system was in place in which all matters needing repair or maintenance were recorded in a book, which in turn was checked by the maintenance person. Records of the servicing of equipment were available and were found to be in date.

There was a well equipped and well stocked kitchen. Environmental health officer reports were available. Kitchen staff had received appropriate training and suitable staff facilities for changing and storage were provided.

There was an enclosed courtyard/garden area with seating for resident and relative use. There was an extensive mural on the courtyard wall which could be seen and enjoyed from others parts of the centre and was much admired and enjoyed by all.

Overall the centre was bright and clean with plenty of different areas to sit including an oratory and hairdressing room.

However inspectors found that there were a few issues in relation to the premises that required improvement:

In one of the bedrooms upstairs the window from the bedroom faced a blank wall which was stained and in need of redecoration. Attention was required to ensure the resident had access to a more suitable view from the window.

There was a lack of signage and pictures around the centre particularly in the area where there were a high percentage of residents with dementia.

Floor covering in a number of areas and in one of the lifts required replacing or repair as it was damaged.

Some equipment was inappropriately stored in sluice rooms and storage areas were not secured.

CCTV was in place throughout the corridors and externally but there was not appropriate signage advising people of that ,nor a policy on the storage of data collected.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

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

Findings:

The complaints policy was posted in the lobby area of the building and the procedure for making a complaint was clear. The last review date on the policy was March 2013 and this required updating. The complaints policy was found to be ambiguous. It could be interpreted that complaints which were resolved at a local level were not recorded nor brought to the attention of the person in charge. In discussions with staff it was evident that complaints were welcomed and dealt with as they arose but were not always recorded and generally if recorded only recorded in the residents notes. The regulations around complaints state that "the nominated person maintains a record of all complaints detailing the investigation and outcome of the complaint and whether or not the resident was satisfied". The regulations also require that complaints are properly recorded and that such records are in addition to and distinct from a resident's individual care plan". This was not taking place, there was a complaints log maintained but this did not contain any complaints even though inspectors noted from the minutes of the residents' forum meetings that there had been complaints expressed by some residents about the food, laundry, and some maintenance issues. There was no evidence that these issues had been addressed.

Inspectors noted the availability of the suggestion box and sheets attached to the complaints policy allowing for complaints to be logged. The person in charge pointed out that he was readily accessible to residents and families and that every effort was made to address complaints at the earliest point to ensure that they did not escalate.

The complaints policy misdirected complainants to the Health Service Executive (HSE) and the Health Information and Quality Authority for resolution of complaints that would normally be the responsibility of the provider and person in charge. There was no information contained in the policy about the role of the Ombudsman's if a complainant was not satisfied with the outcome of a complaint. Different versions of the complaints process were seen in the residents guide, statement of purpose and on display which can lead to confusion.

The issues around complaints have been identified on a number of previous inspections and inspectors were not satisfied that the system in place was sufficiently robust and it did not meet the requirements of legislation and the centre remained non-compliant..

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Care practices and facilities in the centre were designed to ensure that residents received end-of-life care in a way that met their individual needs and respected their dignity and preferences. There were written operational policies and protocols in place however these required review and updating as actioned under outcome 5.

Staff had initiated discussions with residents and relatives about end of life to ensure that their wishes were documented and end-of-life care plans were seen by inspectors in the files of residents. The general practitioner (GP) was involved in advising and supporting residents and relatives if required. Inspectors viewed the care of one resident who was coming towards end of life and were satisfied that the resident was receiving a high standard of individualised care. Individual religious and cultural practices were facilitated, and family and friends were fully involved in planning and were facilitated to be with the resident when they wanted. The resident had the comfort of a single room and access to specialist palliative care services.

Overall residents religious and cultural practices were respected and services were held in the centre weekly. Residents of all religious denominations were visited by their Ministers as required. The palliative care specialists visited the centre if required and would set up the syringe driver in consultation with the GP if required. A number of the staff had specialist end of life training. Staff with whom the inspector spoke said that the care at the end of life was person-centred and inclusive of the relatives. Staff informed the inspector that the families or friends would be given their meals and allowed to visit whenever they wished and facilities would be made available if relatives wished to stay overnight.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy in place on monitoring and documenting residents' nutritional status however as previously identified this required review. Inspectors observed that food and hydration needs were assessed on admission using the malnutrition universal screening tool (MUST) and on a regular basis following same. Inspectors observed mealtimes including breakfast, mid-morning refreshments, afternoon refreshments, lunch and teatime. There was a dining room on each floor and the majority of the residents attended the dining room for their meals and this was seen to be a very sociable experience. Residents requiring assistance were assisted in a dignified and respectful manner by staff. Residents had access to fresh drinking water and snacks were offered between meals and in the evening.

Inspectors saw that referrals were made to the dietician services for nutritional review and advice, and speech and language therapy if a resident had swallowing difficulties (dysphagia). There was evidence available in residents' records that allied healthcare recommendations were implemented by staff, such as the provision of appropriate diets and this was observed by inspectors. There was a system in place for communicating modified or special diets to catering staff and staff members spoken with were knowledgeable of residents' nutritional needs and requirements. Residents were weighed monthly and weekly if there were changes to their weight. There was evident that the documentation of a weight loss/gain prompted an intervention once a concern was identified including the commencement of food and fluid charts. Dietary assessments and nutritional care plans were seen in resident's notes.

On a number of relative and resident questionnaires received prior to the inspection there was a consistent theme looking for more variety of food. However on the inspection inspectors found there was great choice in the food with three separate choices every day for dinner and tea. The chef told inspectors that they regularly reviewed and updated the menu and inspectors found the menus were varied, food appeared to be nutritious and residents were offered a choice at mealtimes. Inspectors also reviewed records of residents' meetings. It was evident that suggestions as regards to food choice were addressed and the chef attended residents meetings as required. Residents spoken to on the days of the inspection expressed satisfaction with the food and the choices available to them.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents were consulted about how the centre was planned and run through the residents' forum which met infrequently. Inspectors saw comprehensive minutes of the last meeting which took place on the 15 August 2016 and the meeting previous to that was held on the 11 November 2015. The frequency of meetings required review. 12 residents attended the meeting and discussed all aspects of living in the centre including food, daily routines, laundry, activities and care. The minutes were made available to management and staff to take action as required following the meeting. There was evidence that residents were enabled to make choices about how they lived their lives in a way that reflected their individual preferences and needs. The choices facilitated their independence. For example, residents were facilitated to exercise their political rights, and voting in elections was accommodated in the centre. Residents' religious rights are facilitated through regular visits by the clergy and the facilitation of services such as mass, rosary and sacrament of the sick.

Residents' capacity to exercise personal autonomy was well respected. For example, provision was made for adequate storage space for clothing and personal possessions; lockable storage was provided and residents had a choice of when to get up and go to bed. The physiotherapist, occupational therapist and physical therapist co-ordinated and ran the activity programme. Facilities for recreation were good and included in-house activities such as art and music, card games, bingo, movie afternoons, quiz, crosswords and exercise classes. Outdoor activities included access to gardens and outings with family and friends. Community activities included the hosting of parties at Christmas, Halloween and birthdays. Residents and relatives stated "the best part of activities is that staff show interest". Inspectors observed there was a relaxed atmosphere in the centre. When commenting about activities, residents stated "there is something on every day" and they look forward to it. One to one activities were provided including encouragement with mobility and therapy assessments and treatment plans.

The statement of purpose emphasised the importance of residents receiving care in a dignified way that respected their privacy. Practices in the centre generally reflected this. For example, doors were closed when personal care was being given. Each resident had their own toiletries. However on both days of the inspection inspectors found that in two of the twin bedrooms screening curtains were missing from around the beds which did not protect the privacy and dignity of the residents.

Signage in relation to residents mobility was very visible on the outside of all residents wardrobes further attention is required to provide more discrete placement of personal information in residents bedrooms.

Residents could access telephone facilities in private. A room was available for residents to receive visitors in private. There were no restrictions on visits except when requested by the resident or when the visit or timing of a visit was deemed to pose a risk. Visitors that spoke to inspectors and who completed questionnaires reported to feeling very

welcome in the centre.

Staff showed awareness of the different communication needs of residents and systems were in place to meet the diverse needs of residents. For example, residents with a cognitive impairment were provided with reminiscence therapy. Residents had access to radio, television, newspapers and information on local events.

Judgment:

Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy on residents' personal property and possessions in place. However, it was out of date and this is actioned under Outcome 5, documentation. There was plenty of storage space provided to residents in their bedrooms and locked storage space was provided for residents to store valuables as required.

Inspectors saw, and residents confirmed, that residents were encouraged to personalise their rooms. Residents' bedrooms were spacious, comfortable and many were personalised with residents' own cushions, ornaments, pictures and photos.

The laundry system was seen by inspectors and found to be satisfactory; residents said they were happy with the laundry facilities. Clothes were discreetly marked and residents reported that clothes generally did not go missing and were returned to residents laundered and in a timely fashion.

Judgment:

Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best

recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

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

Findings:

Residents and relatives spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to the residents.

As on previous inspections, inspectors found the staffing levels and staffing mix were sufficient to meet the needs of residents. Inspectors observed practices and conducted interviews with a number of staff. They observed staff being attentive to residents and performing their duties in a timely manner. Staff members and residents told inspectors that they felt there was enough staff and that they could respond to residents' needs promptly. At least two nurses are on duty at all times as per the duty roster and three nurses on day shifts. This corresponded with what was observed by inspectors on the day and from a sample of staff rosters. Staff were supervised appropriate to their role however there were no staff appraisals conducted and no performance reviews. There had been a high turnover of nursing staff but the person in charge had recruited a number of new nursing staff and nursing staff levels remained consistent. New staff described a comprehensive induction to inspectors where they were supernumerary for a number of shifts and worked beside experienced staff and the ADON. However there were no records or signed induction checklists or of any probation assessments and interviews maintained.

Records indicated that education and training was available to staff to support them in the provision of evidence-based care. However as identified on the last inspection mandatory training was not up to date for all staff in moving and handling, safeguarding, responsive behaviours and as also identified and required on the previous inspection cleaning staff had not received specific training in infection control.

As also identified and action required on previous inspections that all staff members must be made aware of the provisions of the Act and all regulations and rules thereunder, commensurate with their role, the statement of purpose and with any policies and procedures dealing with the general welfare and protection of residents. There was no evidence of copies of the regulations and standards available to staff and some staff spoken to were unaware of the standards and regulations.

Personnel files were well organised with the information easily retrievable. However, not

all contained the documentation as listed in schedule 2 of the Regulations. Where Garda Síochána vetting was not available on file, there was evidence that the applications had been made. One new staff member did not have a reference from their most recent employer and another staff file did not contain any written references. The person in charge said he had obtained verbal references while he waited for the written references to come back but there was no record of the details of the verbal reference recorded. This is actioned under outcome 5 records.

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:

Caroline Connelly
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 Catherine's Nursing Home
Centre ID:	OSV-0000429
Date of inspection:	08/09/2016
Date of response:	07/10/2016

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: Statement of Purpose

Theme:
Governance, Leadership and Management

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

Some of the information as required in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 was not contained in the statement of purpose document such as the conditions attached to the centre's registration, the description of bedrooms did not include the extra rooms registered on the previous inspection, it did not contain the organisational structure of the centre and the arrangements for the management of the centre when the person in

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

charge is absent from the centre.

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

Information as requested to be included.

Proposed Timescale: 01/11/2016

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:

There was not effective management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Annual review to be completed, policies to be reviewed, increase number of audits and risk assessments.

Proposed Timescale: 31/12/2016

Theme:

Governance, Leadership and Management

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

There was no 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 HIQA under section 8 of the Health Act 2007.

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:
To be submitted.

Proposed Timescale: 31/12/2016

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:

Schedule 5 policies and procedures given to inspectors for review were out of date a number dated 2011 and some march or August 2013 which were not reviewed within the three year period as required by legislation. A number of policies required updating to take account of changing legislation and guidelines such as safeguarding policy, end of life policies and medication management. other policies and procedures did not contain enough information to guide practice such as retention of records, fire and emergency procedures and inspectors found all policies required review.

4. 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:

Schedule 5 Policies & Procedures have been reviewed and signed up as necessary. Other policies mentioned in the report in conjunction with Health Care Informed will be in place by December 2016

Proposed Timescale: 31/12/2016

Theme:
Governance, Leadership and Management

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

There were gaps seen in the completion of the directory of residents that required action.

5. Action Required:

Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

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

I suppose we all know in the Nursing Home, the addresses and telephone numbers of our local GPs, so therefore, some staff omit their addresses in the Register. Cause of Death is governed by the GP as a nurse does not have the authority to declare the diagnosis.

Proposed Timescale: Immediately.

Proposed Timescale: 07/10/2016

Theme:

Governance, Leadership and Management

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

Inspectors found in two of the staff files reviewed, references were not in place for one new staff and a reference from the last employer was not in place for the other staff member.

6. 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:

Completed.

Proposed Timescale: 07/10/2016

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:

Inspectors found that not all risks were found to be identified for example, there was no risk assessment for oxygen cylinders stored in an open storage area, two on a trolley for easy access and two separate cylinders stored loosely.
gloves were stored on the corridor and in open bathrooms and required risk assessing
long strings were seen on blinds in residents bedrooms
risk assessments for stairways were not available.
there was open access to a storage area on the first floor

7. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Further risk assessments to be carried out. I have received many policies in the last week from Health Care Informed but we are trying to get a suitable risk assessment form that suits our Nursing Home.

Storage of compressed gas sign installed in areas where emergency oxygen is stored, loose cylinders have been removed.

Open area upstairs is where we park wheelchairs whilst residents are in the dayroom, our emergency Oxygen is stored there for ease of access, this in my opinion should be left open for easy access.

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

Not all staff had received up-to-date fire training.

8. Action Required:

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Fire training ongoing as explained on the day and also on our training matrix.

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:

Door wedges were routinely used in fire doors which made them ineffective. Inspectors saw that these were used on doors throughout the centre on both days of the inspection including doors on corridors which should be used for compartmentalisation in the case of fire.

9. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

All doors have been fitted with Doorgard electronic controls as advised by Fire Officer, wedges have been removed and destroyed.

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

Inspectors were concerned about the safety of residents using the smoking room. While there was a small glass window in the smoking room, due to its location off the corridor there was no visibility for staff and no opportunity to monitor the welfare of residents using the room. The smoking room was not clean with cigarette ash on the floor. The door was open throughout the day and a wedge was seen on the floor. There was an incident completed where a resident fell in the smoking room and did manage to alert staff but inspectors required that the smoking room and visibility and supervision of residents that smoked required urgent review.

10. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Lock mechanism removed from door into smoking room, fire blanket installed and extinguishers serviced.

Proposed Timescale: 27/10/2016

Outcome 09: Medication Management

Theme:

Safe care and support

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

Inspectors also found that the storage of prescription creams and nutritional supplements was not sufficiently robust. Inspectors found prescription creams left on lockers and trays of nutritional supplement drinks stored in residents bedrooms under beds and on top of cupboards and lockers. The storage of all prescription items required review.

11. Action Required:

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Prescription creams to be stored appropriately, shelving put in place to store supplements.

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

Inspectors reviewed a sample of residents medication charts upstairs and downstairs and identified a number of issues with medication prescriptions that required immediate attention:

Inspectors saw that when crushed medications were required this was not appropriately prescribed in this format for two residents charts viewed.

On another residents chart medications had been transcribed by the pharmacist but was not signed by the GP

Another resident had received antibiotics on a faxed prescription for eight days which was not then signed for in house within 72 hours as required by legislation.

Another resident had a prescription for one extra medication faxed onto her original prescription for as required use on the 23 March 2016 which was not signed for by the GP and the resident and never put on the original script but both charts were available which could lead to errors.

Another chart showed an as required night sedation being administered every night but not prescribed on a regular basis.

Nursing staff had continued to administer these medications and these had not been identified or highlighted as errors in fact inspectors were told there were no medication errors in the centre.

12. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

All of the above issues reviewed and resolved. Pharmacist made aware of concerns

Proposed Timescale: 07/10/2016

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:

Inspectors found that there were issues in relation to the premises that required improvement:

In one of the bedrooms upstairs the window from the bedroom faced a blank wall which was stained and in need of redecoration. Attention was required to ensure the resident had access to a more suitable view from the window.

There was a lack of signage and pictures around the centre particularly in the area where there were a high percentage of residents with dementia.

Floor covering in a number of areas and in one of the lifts required replacing or repair as it was damaged.

Some equipment was inappropriately stored in sluice rooms and storage areas were not secured.

CCTV was in place throughout the corridors and externally but there was not appropriate signage advising people of that or a policy on the storage of data collected.

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:

Wall to be painted outside room 14 downstairs (not upstairs).

Pictures being put in place.

Floor covering being replaced, lifts completed already this week.

Inappropriate equipment removed from sluice rooms.

CCTV Policy being implemented as we have received assistance from Health Care Informed.

Proposed Timescale: 30/11/2016

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The complaints policy was found to be ambiguous and a number of different versions of the complaints procedure were found in different documents in the centre..

14. Action Required:

Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

Compiling an updated version of Complaints Policy.

Proposed Timescale: 31/12/2016

Theme:

Person-centred care and support

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

Complaints were not fully and properly recorded including the results of any investigations into the matters complained of and any actions taken on foot of a complaint. Records of complaints were not in addition to and distinct from a resident's individual care plan.

15. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

Complaints Register in place, awaiting first complaint.

Proposed Timescale: 07/10/2016

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

On both days of the inspection inspectors found that In two of the twin bedrooms screening curtains were missing from around the beds which did not protect the privacy and dignity of the residents.

Signage in relation to residents mobility was very visible on the outside of all residents wardrobes further attention is required to provide more discrete placement of personal information in residents bedrooms.

16. Action Required:

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

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

Curtains replaced, mobility signage to be placed inside wardrobe door despite reservations from physiotherapist, occupational therapist and nursing staff.

Proposed Timescale: 30/11/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

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

As identified on the last inspection mandatory training was not up to date for all staff in moving and handling, safeguarding, responsive behaviours and as also identified and required on the previous inspection cleaning staff had not received specific training in infection control.

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:

I gave the HIQA Inspectors times and dates of our training programme, Optima Training are the group doing the training. All training as stated on the training programme will be completed by December 2016.

Proposed Timescale: 31/12/2016

Theme:
Workforce

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

There was no formal system for appraisal, induction and probationary periods for staff.

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:

Induction Programme, appraisals to be agreed with staff over the next 6 months.

Proposed Timescale: 27/04/2017

Theme:
Workforce

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

As also required on previous inspections all staff members must be made aware of the provisions of the Act and all regulations and rules thereunder, commensurate with their role, the statement of purpose and with any policies and procedures dealing with the general welfare and protection of residents. There was no evidence of copies of the

regulations and standards available to staff and some staff spoken to were unaware of the standards and regulations.

19. Action Required:

Under Regulation 16(1)(c) you are required to: Ensure that staff are informed of the Act and any regulations made under it.

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

Copies of Standards and Regulations to be placed at nursing stations

Proposed Timescale: 31/12/2016