Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Kilrush District Hospital Limited
Centre ID:	OSV-0000446
Centre address:	Cooraclare Road, Kilrush, Clare.
Telephone number:	065 905 1966
Email address:	kilrushdistrictlimited@yahoo.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Kilrush District Hospital Limited
Provider Nominee:	John Hehir
Lead inspector:	Mary Costelloe
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	10

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
23 May 2016 09:00	23 May 2016 17:30
24 May 2016 09:00	24 May 2016 15:30

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	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation		Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Non Compliant - Major

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Authority. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. Prior to the inspection, the person in charge completed the provider self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care

Settings for Older People in Ireland.

While this centre does not have a dementia specific unit the inspector focused on the care of residents with a dementia during this inspection. Eight residents were either formally diagnosed or had suspected Alzheimer's disease or dementia. The inspector met with residents, relatives, and staff members during the inspection. The inspector tracked the journey of a number of residents with dementia within the service, observed care practices and interactions between staff and residents who had dementia. The inspector also reviewed documentation such as care plans, medical records, staff files, relevant policies and the self assessment questionnaire which were submitted prior to inspection.

The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

The new extension was finished to high standard and included accommodation for fifteen residents in nine single and three twin bedrooms all with en suite facilities.

As part of the reconfiguration plan for the original building the dining room had recently been extended to provide adequate accommodation for all residents. A separate private visitors space had also been provided.

Staff continued to strive to improve the type and variety of activities to ensure that meaningful and interesting activities were provided for all residents. Detailed life histories had been documented for most residents and staff were observed to use this information when conversing with residents.

Residents were observed to be relaxed and comfortable in the company of staff. Staff had paid particular attention to residents dress and appearance. The inspector noted that staff assisting residents with a dementia were particularly caring and sensitive.

The collective feedback from relatives was one of satisfaction with the service and care provided.

Staff were offered a range of training opportunities, including a range of specific dementia training courses.

Improvements were required to nursing documentation, mandatory training for staff in elder abuse and fire safety, ensuring privacy and dignity for all residents, ensuring residents can exercise choice, the design and layout of parts of the older building, setting out the roles and responsibilities of volunteers and staffing.

These areas for improvement are discussed further throughout the report and in the action plan at the end of the report.

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

Outcome 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:
The inspector found that residents' overall healthcare needs were met and they had access to appropriate medical and allied healthcare services and each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Some improvements were required to the nursing documentation.

Residents had access to general practitioner (GP) services of their choice and could retain their own GP if they so wished. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis. The inspector reviewed a sample of medication prescription/administration charts and noted that medications were regularly reviewed and administered as prescribed.

A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services, tissue viability and psychiatry of later life. Chiropody and optical services were also provided. The inspector reviewed residents' records and found that residents had been referred to these services, regularly reviewed and results of appointments were written up in the residents' notes.

There was a policy in place that set out how resident's needs would be assessed prior to admission, on admission, and then reviewed at regular intervals. A review of the records showed that this was happening in practice. All residents had a care plan that was developed on admission, and this was added to as the staff got to know the resident better.

Comprehensive up-to-date nursing assessments were in place for all residents. A range of up-to-date risk assessments were completed for residents including risk of developing pressure ulcers, falls risk, nutritional assessment, dependency, moving and handling, pain, oral cavity and risk.

The inspector noted that care plans were in place for all identified issues. Some

residents with a dementia had specific care plans in place. They included guidance for staff regarding residents with communication issues, at risk of absconsion, at risk of isolation secondary to progressive dementia and malnutrition. The inspector noted that while care plans were regularly reviewed and the progress notes were updated, the care plans did not always reflect the changed needs of some residents. While the inspector noted many improvements to the nursing documentation since the previous inspection, some care plans were still not person centered.

There was evidence of relative/resident involvement in the review of care plans. Nursing staff and health care assistants spoken with were familiar with and knowledgeable regarding residents up to date needs.

Nursing staff told the inspector that a detailed hospital transfer letter was completed when a resident was transferred to hospital. The transfer letter template included areas to record appropriate information about their health, medications and their specific needs. However, the inspector noted that copies of the transfer letters were not always kept on file, the person in charge undertook to ensure that a copy of same would be kept going forward. The person in charge told the inspector that residents with a dementia were always accompanied by either a family or staff member when needing transfer to hospital.

The inspector reviewed the file of a resident with a wound and noted adequate wound assessment and wound care charts in place. Staff had access to support from the tissue viability nurse if required.

The inspector was satisfied that residents weight changes were closely monitored. All residents were nutritionally assessed using a validated assessment tool. All residents were weighed regularly. Nursing staff told the inspector that if there was a change in a resident's weight, nursing staff would reassess the resident, inform the GP and referrals would be made to the dietician and speech and language therapy (SALT). Files reviewed by the inspectors confirmed this to be the case, the dietician and SALT regularly reviewed at risk residents. Nutritional supplements were administered as prescribed. All staff were aware of residents who required specialised diets or modified diets and were knowledgeable regarding the recommendations of the dietician and SALT.

The daily menu was displayed and choice was available at every meal. The inspector observed the lunch time meal experience and noted it to be a pleasant one. Lunch and evening meals were served to residents in the ground floor dining room. Breakfast was served to most residents in their bedrooms, however, breakfast was served to a small number of residents in a first floor unoccupied ward style room which was totally unsuitable. This is discussed further under Outcome 3 Residents rights, dignity and consultation, Outcome 6 Safe and suitable premises. The ground floor dining room had recently been increased in size and all residents could now be facilitated at one sitting. Some residents choose to have their meals in their bedroom and this was facilitated. Staff were observed to engage positively with residents during meal times, offering choice and appropriate encouragement while other staff sat with residents who required assistance with their meal. The inspector noted that staff assisting residents with a dementia were caring and sensitive, they explained what foods were on offer and gently reminded some to swallow. Modified consistency diets were nicely presented and

included a variety of texture and colour. Many staff had received recent training in relation to dysphagia and nutrition.

The inspector reviewed the files of residents who had recently fallen and noted that the falls risk assessments, care plans had been updated and a post falls review completed. The person in charge reviewed falls on a regular basis, there was evidence of learning and improvement to practice. Low-low beds, crash mats were in use for some residents. The inspector noted that the communal areas were supervised by staff at all times.

Staff provided end of life care to residents with the support of their GP and the homecare palliative team. The inspector reviewed a number of 'end of life' care plans that outlined the individual wishes of residents and their families including residents' preferences regarding their preferred setting for delivery of care. Files reviewed indicated that residents were referred, reviewed and assessed by the palliative care team. Many staff had undertaken training in end of life care.

Staff informed the inspector that they continued to strive to improve the type and variety of activities to ensure that meaningful and interesting activities were provided for all residents. The social care needs of each resident were assessed and records were maintained of each residents participation in activities. Detailed life histories had been documented for most residents and staff were observed to use this information when conversing with residents.

There was a full time activities coordinator employed in the centre during the afternoon and evenings, care staff supervising the day room carried out activities with residents in the morning time. An external facilitator visited weekly and involved some residents in a Sonas (therapeutic programme specifically for residents with Alzheimer's or dementia). The activities coordinator was scheduled to attend Sonas training in July 2016. Musicians visited regularly, the local priest visited and celebrated mass weekly. Many of the residents actively partook in activities while others joined in for shorter periods. Other activities that took place regularly included light exercise to music, arts and crafts, ball exercises, bingo, quizzes, cross words, reminiscence, storytelling and pet therapy. Some residents had recently visited the local museum and gone for a trip to the local town. Staff told the inspector that they planned to go on many day trips to local areas of interest during the summer months and that the centre had its own minibus available to transport residents.

Staff told the inspector that some residents with a dementia did not like partaking in large group activities and preferred smaller group activities such as Sonas or one to one activities such as gentle hand massage, relaxation therapy, aroma therapy, reflexology and pet therapy. Almost all residents loved music and many were observed singing along with staff during the inspection. The inspector observed staff having conversations with residents and engaging with different activities such as holding dolls or soft toys. Staff were seen to interact with residents positively, speaking directly to people, responding to any verbal communication, kneeling by people and getting eye contact and some physical contact.

The person in charge told the inspector that they planned to introduce some gardening activities and discussed plans to provide raised planting beds in the new outside garden

area. Residents currently did not have access to an safe secure garden area. This is discussed further under Outcome 6 Safe and suitable premises.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
The provider and person in charge had taken some measures to safeguard residents from being harmed and from suffering abuse, however, some staff and a volunteer had not received training in elder abuse and training for other staff was not up to date. The rationale for the use of some bedrails was not always clearly documented.

There were comprehensive recently updated policies on protection of residents from abuse. Staff spoken with were knowledgeable on the topic and aware of their responsibilities. However, some staff had not received training while other staff did not have up to date training. The person in charge told the inspector that formal elder abuse training was scheduled for 11 July 2016 but she undertook to carry out in house training with all staff immediately. At the time of the inspection, no recent allegations had been made and the person in charge was clear on what her role would be.

The finances of some residents were managed in the centre and small amounts of money were kept for safe keeping on behalf of a number of residents. The inspector saw that these accounts were managed in a clear and transparent manner. Separate accounts were kept for each resident detailing all transactions. Two signatures were recorded for each transaction and receipts were kept for any purchases made on behalf of residents.

The inspector reviewed the policies on meeting the needs of residents presenting with challenging behaviour and restraint use. The policy on behaviours that challenged outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged. The policy on restraint was based on the national policy and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. There were 15 bed rails in use at the time of inspection. The inspector noted that while risk assessments had been completed, the rationale for the use of bedrails was not always clear. Care plans were in place to guide the care of residents using bedrails and the inspector saw that alternatives such as low low beds

and crash mats were in use for some residents.

The person in charge and other staff informed the inspector that there were no residents presenting with challenging behaviour at the time of inspection. There was evidence of access and referral to psychiatry services and ABC charts were used to record episodes of behaviours in line with the centres policy.

Staff spoken with and training records reviewed indicated that staff had attended training on dementia care, dealing with behaviours that challenged and management of restraint.

The inspector observed staff interacting with residents in a respectful and friendly manner. Residents were observed to be relaxed and happy in the company of staff. Relatives spoken with felt their relatives were being supported by excellent staff and receiving good care.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Residents were supported to contribute ideas and to participate in the day to day activities of the centre. Feedback was sought from residents and their families. Improvements were required to ensure privacy and dignity of all residents was respected, to ensuring choice of dining location and access to safe outdoor space.

Residents committee meetings were held on a regular monthly basis and were facilitated by the activities coordinator. Notice of upcoming meetings were displayed and relatives were invited to attend. Minutes of meetings were recorded, issues discussed included catering/food, activities, day trips, comment/complaints, birthday parties and any other issues residents or relatives wished to discuss. The activities coordinator told the inspector that any recommendations or wishes regarding food were discussed with the catering department who always followed through with any requests. She had recently organised some day trips to local areas of interest following requests from some residents.

Quality assurance questionnaires were forwarded to all residents /relatives on a six monthly basis and included feedback on areas such as management, meal time and nutrition, daily living, premises, dignity and respect, personal care and support. The person in charge told the inspector that she reviews all completed questionnaires and

addresses any issues that are raised. The inspector reviewed some of the most recently completed questionnaires and noted that feedback was generally very positive.

Information leaflets regarding the national advocacy service SAGE(Support and Advocacy Service for Older People) were displayed in the centre. The person in charge advised that information leaflets had been given to all residents and their families.

The inspector noted that while the privacy and dignity of residents was generally respected the inspector had concerns that the open glass shutters on the doors of bedrooms in the new extension did not provide those residents with privacy and dignity when left open. On both days of inspection the inspector observed that the shutters were open to some bedrooms and the privacy and dignity of those residents was compromised. The person in charge informed the inspector that the shutters were left open so that staff could check on residents without disturbing them. Bedroom/ bathroom doors were closed and screening curtains fully enclosed beds when personal care was being delivered. The design and layout of parts of the building in particular the five bed multi occupancy bedroom also compromised residents dignity and privacy. The provider has submitted plans to the Authority to convert this room to two twin bedrooms with en suite toilet/shower facilities.

Residents were treated with respect. Inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents' appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear. The hairdresser visited weekly and some residents availed of the service while other residents were supported to attend their own hairdresser locally.

While staff were observed offering choice such as choice of preferred drinks, preferred meal option and preferred place to sit, some residents did not have the choice of having breakfast in the ground floor dining room also discussed under Outcome 1 Health and social care needs and Outcome 6 Safe and suitable premises. Residents did not have the choice of spending time outside as they did not have independent access to a safe outdoor area also discussed under Outcome 6 Safe and suitable premises.

Residents' religious and political rights were facilitated. The local priest visited and said Mass weekly. Residents told the inspector that they enjoyed attending mass and reciting the daily rosary. Some residents listened to daily mass via radio link from the local parish church. The person in charge told the inspector that residents were facilitated to vote and explained that residents had been facilitated to vote in-house during the recent general election while some residents were supported by staff to vote in their home polling station.

There was an open visiting policy in place. Residents could meet with family and friends in private if they wished, or could meet in their rooms, or communal areas of the home. Residents had many visitors during the inspection and relatives spoken with were very complimentary of the service provided.

Judgment:
Non Compliant - Moderate

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:
There was a comprehensive complaints policy in place which clearly outlined the duties and responsibilities of staff. The complaints procedure was clearly displayed and contained all information as required by the Regulations including the name of the complaints officer and details of the appeals process.

The inspector reviewed the complaints log, there were no complaints recorded for 2016. Fifteen complaints were recorded for 2015, all had been investigated and responded to and included complainants' satisfaction or not with the outcome. There were no open complaints.

Judgment:
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:
The inspector found that while there was an appropriate number and skill mix of staff on duty, work organisation required review in order to meet the needs of all residents. An assistant director of nursing (aDoN) had been appointed to support the person in charge and supervise the delivery of care since the previous inspection.

There were normally two nurses and six care staff on duty in the mornings and afternoon, two nurses and three care staff on duty during the evening time and two nurses and two care staff on duty at night time from 21.00. The activities coordinator worked from 14.00 to 21.00 Monday to Friday.
The person in charge was normally on duty during the daytime Monday to Friday and the aDoN was normally on duty four days a week. The person in charge and aDoN were on call out of hours and at weekends. Duty rosters reviewed indicated that these

staffing levels were the norm and the nurse in charge of each shift was easily identified.

The inspector observed two residents sitting in wheelchairs at tables in the first floor ward style room called St. Bridget's. Residents spoken with informed the inspector that they normally have their breakfast in this room about 7.30am and sit there until staff were available to assist them to the ground floor day room, usually between 9.30 and 10.00 am. Both residents informed the inspector that they liked to get up early and have breakfast. Nursing staff informed the inspector that St Bridget's ward was used to accommodate the supervision of these residents as there were inadequate staff downstairs to supervise the dining room. The person in charge undertook to review work organisation in order to facilitate resident choice and supervision of residents.

Staff spoken with and records reviewed indicated that all staff had not completed mandatory training in areas such as safeguarding and prevention of abuse and fire safety. Fire safety training was scheduled for 31 May 2016 and elder abuse training was scheduled for 11 July 2016.

The staff had access to a range of education, including training in specific dementia care training courses, restraint management, dealing with behaviours that challenge, infection control, medication management, end of life care, continence and nutrition. The activities coordinator was scheduled to attend Sonas training in July 2016. The aDon was currently undertaking a Masters Degree in Dementia care.

There were robust recruitment procedures in place. Staff files reviewed were found to contain all the required documentation as required by the Regulations. Garda Síochána vetting was in place for all staff. Nursing registration numbers were available for all staff nurses. However, the roles and responsibilities of volunteers were not set out in writing. Details of induction/orientation received, training certificates and appraisals were noted on staff files.

Judgment:
Non Compliant - Moderate

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 was satisfied that the new large two storey recently opened extension met the needs of residents. The new extension was finished to high standard and included accommodation for fifteen residents in nine single and three twin bedrooms all with en suite facilities. There was a large bright entrance lobby area with seating and an

additional day room located on the first floor. The corridors were wide and bright and allowed for freedom of movement. Corridors had grab rails, and were seen to be clear of any obstructions.

However, as stated in previous inspection reports the inspector noted that the design and layout of parts of the older building did not meet with the needs of residents or comply with the requirements of Regulations, in particular the multi occupancy bedrooms. The existing centre was built as the original district hospital and has been extended and reconfigured over the years. Following the last inspection, the provider submitted a plan of works for reconfiguration of the older building in order to comply fully with the requirements of the Regulations. As part of that plan the dining room in the original building had recently been extended to provide accommodation for all residents with direct access from the kitchen area. A separate private visitors space had also been provided.

During the inspection the provider told the inspector that reconfiguration works had been prioritised and would be carried out in order. He stated that moving the first floor nurses office was the next priority.

Residents did not have access to a safe, secure garden area. The provider spoke of plans to address this issue and he expected it to be completed shortly.

The first floor unoccupied ward style room called St. Bridget's which was being used as a dining and sitting area for some residents was unsuitable for use, residents could not see out as there were no windows except for velux roof windows. The unsuitability of this room had previously been brought to the attention of the provider and person in charge. Both residents told the inspector that they felt cold on the morning of the inspection. The room was dark and dreary and had not been designed for use as a dining room/sitting room.

Signage throughout the centre was limited particularly on the first floor, signage had not been designed to aid persons with a dementia.

The inspector noted that the meal service trolley in use made a loud noise on corridors, one resident told the inspector that the noise from it was terrible especially in the mornings.

There was a range of equipment in the centre to aid mobility. Hoists and other equipment seen in the centre were in working order, and records showed they had been regularly serviced. Staff records showed that staff had completed manual handling training in relation to the equipment available in the centre.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

Findings:
While the inspector did not inspect specifically against this outcome, issues of concern were noted regarding fire safety training and staff knowledge on fire safety in particular evacuation of residents in the event of fire or other emergency.

Training records reviewed indicated that not all staff had up to date fire safety training. Staff spoken with told the inspector that they had attended fire safety training however, they were not clear regarding the evacuation of residents from the first floor in the event of fire. Staff including senior nursing management were not clear regarding the fire retardancy of fire doors or horizontal evacuation in the event of fire. Staff had documented a personal emergency evacuation plan(PEEP) for each resident which was displayed in residents bedrooms. However, guidance outlined for staff in some plans reviewed did not reflect best practice in relation to fire safety evacuation, for example some instructions documented that two staff assist an immobile resident using a ski sheet and evacuate by going directly down the nearest stairs. These issues of concern were brought to the attention of the person in charge and person representing the provider. They immediately contacted their fire safety consultant to arrange training and guidance for staff. The fire safety consultant visited the centre on the day of inspection, arranged training for staff and undertook to review the fire and emergency policy. The person in charge advised that fire safety training was scheduled for 31 May 2016.

Judgment:
Non Compliant - Major

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:

Mary Costelloe
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Kilrush District Hospital Limited
Centre ID:	OSV-0000446
Date of inspection:	23/05/2016
Date of response:	22/06/2016

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:
Care plans were not always updated to reflect the changed needs of some residents.

1. 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

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

family.

Please state the actions you have taken or are planning to take:
All the assessment and care plans were reviewed. Care plans and assessments updated after the inspection to reflect the changed needs of some residents. Nurses have allocated residents in which they are responsible to update and maintain their care plan. Updated care plans and assessments have now been carried out and will be on going. Residents care plans for currently no existing complaints were updated and closed. Care plans are updated 3 monthly or before if residents need change to allow continuity and quality of care.

Proposed Timescale: 10/06/2016

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 rationale for the use of some bedrails was not always clearly documented.

2. 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:
Restraint risk assessment reviewed. The rational for the use of bed rails which were not in place at the time of inspection are now clearly documented and in place. All the restraints used in the premises are in accordance with National Policy of Department of Health.

Proposed Timescale: 08/06/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff had not received training in elder abuse and training for other staff was not up to date.

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

Please state the actions you have taken or are planning to take:
Elder Abuse Training is scheduled Annually for all Staff. The next scheduled training is on 11th July for all current staff and voluntary staff to comply with the regulatory requirement under regulation 08(2)

Proposed Timescale: 11/07/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The open glass shutters on the doors of bedrooms in the new extension did not provide those residents with privacy and dignity when left open. On both days of inspection the inspector observed that the shutters were open to some bedrooms and the privacy and dignity of those residents was compromised. The design and layout of parts of the building in particular the five bed multi occupancy bedroom also compromised residents dignity and privacy.

4. 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:
All the staff were educated about the importance of maintaining the resident's privacy and dignity at all times. A regular monitoring system is established by the senior nursing management and the nursing staff on duty each shift to ensure the privacy and dignity of the residents.

Proposed Timescale: 25/05/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents did not have the choice of having breakfast in the ground floor dining room.
Residents did not have the choice of spending time outside as they did not have independent access to a safe outdoor area.

5. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
Arrangements were put in place after the inspection for the residents who wish to have their breakfast in the downstairs dining room. Staff re arranged by the nursing management to facilitate supervision for the residents. (25/05/2016)
Residents have access to our garden from new extension via access ramp installed. They have also access via the dining room. Pot Plants etc in garden area in front of day room to be installed where residents can view on daily basis. We are also currently in discussions with the HSE for use of their large green house on site so that residents can partake in meaningful activities on an ongoing basis. (15/07/2016)

Proposed Timescale: 25/05/2016 and 15/07/2016

Proposed Timescale: 15/07/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector observed two residents sitting in wheelchairs at tables in the first floor unoccupied ward style room called St. Bridget's. Residents spoken with informed the inspector that they normally have their breakfast in this room about 7.30am and sit there until staff are available to assist them to the ground floor day room, usually between 9.30 and 10.00 am. Both residents informed the inspector that they liked to get up early and have breakfast. Nursing staff informed the inspector that St Bridget's ward was used to accommodate the supervision of these residents as there were inadequate staff downstairs to supervise the dining room.

6. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The premises already stopped the practice of using the St. Bridget’s ward for residents dining or sitting after the inspection. Staff levels re arranged by the nursing management to facilitate the supervision for the residents especially in the mornings to ensure that the number and skill mix of staff is appropriate to the needs of the residents.

Proposed Timescale: 25/06/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff spoken with and records reviewed indicated that all staff had not completed mandatory training in areas such as safeguarding and prevention of abuse and fire safety.

7. 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:
Mandatory Fire Safety training was conducted for all the current and the voluntary staff on 31st May 2016. Elder abuse is scheduled for current and voluntary staff on 11th July 2016. Nursing Management will be conducting on-going in-house training for the Staff in areas such as Safe Guarding and prevention of Abuse.

Proposed Timescale: 31/05/2016 and 11/07/2016

Proposed Timescale: 11/07/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The roles and responsibilities of volunteers were not set out in writing.

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

Please state the actions you have taken or are planning to take:
We have put in place the roles and responsibilities of voluntary staff including Job Description.

Proposed Timescale: 25/05/2016

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:
The design and layout of parts of the older building did not meet with the needs of residents or comply with the requirements of Regulations, in particular the multi occupancy bedrooms.

Residents did not have access to a safe, secure garden area.

The first floor unoccupied ward style room called St. Bridget's which was being used as a dining and sitting area for some residents was unsuitable for use, residents could not see out as there were no windows except for velux roof windows. The unsuitability of this room had previously been brought to the attention of the provider and person in charge. Both residents told the inspector that they felt cold on the morning of the inspection. The room was dark and dreary and had not been designed for use as a dining room/sitting room.

Signage throughout the centre was limited particularly on the first floor.

The meal service trolley in use made a loud noise on corridors.

9. 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 premises has already stopped the practice of using the St. Bridget's ward for residents dining or sitting after the inspection. Signage was already in place in the building. A review of signage on the First Floor has taken place will be updated.

The meal service trolley has been serviced on 30/05/2016.

The layout of St. Bridget's Ward is to be reorganised as part of the design of the old Building Layout. 31/10/2016

Proposed Timescale: 31/10/2016

Outcome 07: 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:
Training records reviewed indicated that not all staff had up to date fire safety training. Staff spoken with were not clear regarding the evacuation of residents from the first floor in the event of fire. Staff including senior nursing management were not clear

regarding the fire retardancy of fire doors or horizontal evacuation in the event of fire. Guidance outlined for staff in some personal emergency evacuation plans (PEEP) reviewed did not reflect best practice in relation to fire safety evacuation.

10. 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:

Immediate arrangements were made for the fire safety training and was conducted for all the current and voluntary staff on 31st May 2016. All the Staff received the training in fire prevention and emergency procedures including evacuation process, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment and fire control techniques and procedures. At present all the staff in the premises are very clear regarding the fire retardancy of the fire doors both old and in the new extension and the progressive horizontal evacuation plan in the event of a fire. The current Personal Emergency Plan (PEEP) was reviewed on 13/06/2016 on the 1st floor and a new PEEP is in place for all the residents to reflect the best practice in relation to fire safety evacuation.

Proposed Timescale: 31/05/2016, 13/06/2016

Proposed Timescale: 13/06/2016