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:	Lystoll Lodge Nursing Home
Centre ID:	OSV-0000246
Centre address:	Skehenerin, Listowel, Kerry.
Telephone number:	068 24248
Email address:	lystoll.lodge@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Lystoll Lodge Nursing Home Limited
Provider Nominee:	Christine McElligott
Lead inspector:	Mary O'Mahony
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	0

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.

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

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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:
06 April 2017 13:00	06 April 2017 19:00
07 April 2017 09:30	07 April 2017 18:45

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 - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures		Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Compliant

Summary of findings from this inspection

This inspection of Lystoll Lodge Nursing Home by the Health Information and Quality Authority (HIQA) was unannounced and took place over two days. This inspection report sets out the findings of a thematic inspection, which focused on specific outcomes, relevant to dementia care. The inspector followed the experience of a number of residents with dementia, within the service. Care practices and interactions between staff and residents who had dementia, were observed, using a validated observation tool. As part of the thematic inspection process, providers were invited to attend information seminars organised by HIQA. In addition, evidence-based guidance was developed to guide providers, on best practice in dementia care and on the inspection process. The person in charge completed the provider self-assessment tool on dementia care.

On the day of the inspection there were 48 residents in the centre. The centre was

located in a quite rural area, near to Listowel town, with scenic views of the surrounding countryside. The garden was furnished with suitable outdoor seating and colourful ornaments and plants. residents had contact with relatives, friends and the community and had an active social life within the centre. Staff were seen to be familiar with residents' likes and dislikes and staff were known to residents.

As part of the dementia thematic inspection process, the inspector met with residents, visitors, the person in charge, the deputy person in charge, staff nurses, care staff, the activity co-ordinator and catering staff. The person in charge informed the inspector that the provider would not be available for the two days of the inspection. The inspector reviewed documentation such as, care plans, medical records, allied healthcare records and policies. A number of staff files and residents' care plans were checked for relevant documentation. The person in charge informed the inspector that she was involved in the centre on a daily basis and was supported in management by the deputy person in charge.

The Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016, formed the basis for judgments made by the inspector. The inspector found that improvements were required in the areas of staff training, staff files, documentation and governance and management. Following the previous inspection of 11 and 12 May 2016 a provider meeting had been convened in the head office of HIQA, following findings of non-compliance. However, on this inspection the inspector found that a number of the required actions, from that inspection, had yet to be completed. The areas of continued non-compliance, were set out in this 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 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Clinical assessments such as falls assessment, nutrition assessment, MUST (Malnutrition Universal Assessment Tool), skin assessment and cognitive assessment were completed for residents with dementia. The person in charge informed the inspector that residents had access to regular general practitioner (GP) and pharmacy services. In addition, medicines were reviewed by GPs on a three-monthly basis. Regular GP visits were recorded and physical and psychological aspects of care of residents with dementia were seen to be addressed as documented in the medical notes. Specialist services and allied health care services such as, occupational therapy (OT) were available by referral. Speech and language (SALT), dietician, optician, dental and physiotherapy services were seen to have been availed of. Residents were facilitated to access chiropody and hairdressing within the centre on a regular basis.

For residents with dementia a comprehensive assessment of residents' health and social care needs took place prior to admission and this was undertaken by the person in charge, A sample of this documentation was viewed by the inspector. Appropriate care plans were seen to be in place, which were reviewed four monthly. Residents and their representatives were involved in developing care plans. Residents' signatures were seen on consent forms within the care plan and on their contracts of care. Since the previous inspection documentation in care plans was more comprehensively maintained and information for each resident was contained in individual files. However, similar to findings on the previous inspection the inspector found that there were a number of discrepancies in the sample of care plans reviewed. For example, the physiotherapist had documented that a resident's needs had increased and he now required a 'sling hoist' for movement. The inspector found that a care plan entry which was recorded following this assessment indicated that there was 'no change' to the resident's mobility needs and that the resident still used a 'standing' hoist for movement. A similar entry was seen for a second resident. A further example of a discrepancy in the care plan of a resident with dementia involved an entry which stated that the resident could 'eat independently'. This had been updated and reviewed as 'no change'. The person in charge confirmed however, that the resident now required support with meals as

witnessed by the inspector during the inspection. This was also confirmed in a second care plan in the resident's file. In addition, a number of dates in care plans were not complete. For example, it was not clear to the inspector when a number of care plans had been commenced as the dates were recorded as follows; 19/11 and 22/09. Furthermore, a resident was identified as requiring a monthly MUST score to be recorded. Documentation to this effect was not recorded on the file.

Life story information was used to inform the activity programme and the daily preferred routine of each resident. The inspector spoke with the activity co-ordinator who explained the benefit of group and individual activity for each resident. The activity coordinator stated that access to radio, favourite programmes and daily newspapers was also facilitated. Additional activities and opportunities to socialise were discussed under Outcome 3: Residents' rights dignity and consultation.

Residents with dementia were supported to maintain their independence. There was an emphasis on promoting health and wellbeing. Residents were encouraged to participate in the social life of the centre. During the inspection a physiotherapist was providing exercise classes to residents. Residents informed inspectors that this was a weekly occurrence. Residents participated in chair-based exercises and individual walking and strengthening exercises with the physiotherapist and staff. The inspector spoke with the physiotherapist who was employed by the nursing home to attend the centre on a weekly basis. On one day of the inspection he had been asked to see 18 residents. Some residents had a private arrangement with him when physiotherapy was required following a hospital stay or for on-going medical issue. He explained that residents with dementia also participated in games such as ball throwing and skittles. He also supplied an individual exercise sheet where appropriate. These exercise sheets were seen in residents' files. Residents informed the inspector that this regular access to physiotherapy had reduced hospital admissions and had alleviated for example, chronic chest conditions. The physiotherapist stated that where specific equipment was required for residents the provider supplied this. The physiotherapist was found to be knowledgeable of residents' needs. Residents with dementia were seen to be familiar with him and content in his presence.

Medication management systems were guided by an updated policy and procedure. A sample of medicine records for residents with dementia were checked by the inspector. These appeared to be generally in order. However, the inspector found that a number of signatures had not been recorded for the administration of medicine as required by An Bord Altranais guidance for nurses on medication management. Staff informed the inspector that the pharmacist attended the centre regularly and was available to speak with residents, if required.

Relatives who spoke with the inspector, were praiseworthy of the care available to residents and the family at end of life. There was an oratory available for relatives and they were encouraged to stay overnight in the centre. The holistic needs of dying residents were met, for example, skin care and oral care were attended to and spiritual needs were addressed. The inspector observed documentation in a resident's file which confirmed this. Mass was available to residents on a regular basis. During the inspection a large group of residents attended a blessing ceremony delivered by the local priest.

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:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. This had been reviewed on 05/09/2016. Staff spoken with by the inspector were aware of the types of elder abuse and of what to do in the event of an allegation, suspicion or disclosure of an alleged incident. However, not all staff had been afforded the required mandatory training in the prevention of elder abuse. This was seen to be next scheduled for 05/05/2017. Residents spoken with, informed inspectors that they felt safe and could report concerns to the person in charge or provider.

Since the previous inspection a nightly log of the use and safety of bed rails was maintained. Appropriate risk assessments and consent forms were seen to be in place for residents. The inspector found however, that a number of staff spoken with had not received updated knowledge and skills in managing behaviours which occurred due to the impact of dementia. This was a mandatory requirement under the regulations. The inspector reviewed the policy on the management of these behaviour and psychological symptoms of dementia (BPSD) which was updated in 2016. The policy stated that the provision of such training was an essential element in the implementation of the policy and that "staff are trained and supervised to manage behaviour...". The non-compliance with regulations was discussed with the person in charge. In addition, aspects of the centre's policy on the prevention of elder abuse had not been implemented or adopted in relation to the recruiting and vetting of staff. This was addressed under Outcome 5: Staffing.

Systems were in place to safeguard residents' money and this system was monitored by the provider, the person in charge and administration staff. This system included two staff members signing for any money lodged or withdrawn. A sample of records checked were seen to be in order. However, in relation to financial arrangements, receipts were not given for all cash received from relatives. The inspector discussed the system of record keeping with the administration staff. For example, when cash payments were received the name of the person who paid was recorded in the daily diary. The amount received was not recorded. This was acknowledged in the invoice sent out to relatives. However, the inspector formed the view that the system in place for receiving cash payments was not comprehensive or secure.

Non-compliance with regulations in relation to the requirements of documentation in staff files for example, Garda vetting, references and employment history was addressed under Outcome 5: Staffing.

Judgment:
Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
There were opportunities for residents to participate in activities which suited their needs interests and capacities. For example, residents with cognitive impairment were provided with reminiscence therapy, old movies, chair based exercises, art and one-to-one activity. Residents who enjoyed keeping up-to-date with current affairs were provided with daily newspapers and access to TV. Minutes of residents' meetings indicated that a range of activities such as, bingo, playing cards, music, dancing, singing, mass, cinema nights, massage, physiotherapy exercises and parties were part of weekly life in the centre. Visitors were plentiful and residents were seen to go out to visit family and to attend appointments. Residents and relatives with whom the inspector spoke confirmed these events and that they had access to a varied activity programme. Afternoon tea parties were held which provided a reminiscence opportunity for residents according to the activity coordinator. Each resident's privacy and dignity was respected including receiving visitors in private. Residents informed the inspector that they were encouraged to exercise choice and to maintain control over their daily lives. Residents were facilitated to exercise their civil, political and religious rights. They spoke with the inspector about local and national events. Religious rights were supported through regular visits by the clergy and the provision of appropriate religious services.

There were a number of photographs on display which indicated that special occasions were celebrated throughout the year. In addition, there were photographs on display of visiting musicians, choirs and school groups. An independent advocacy service was accessible to residents. The person in charge stated that the service had been availed of for some residents. The person in charge stated that since the previous inspection residents were enabled to access the garden more frequently with assistance and with the support of staff, when required. Residents informed the inspector that they enjoying spending time in the garden at barbeques and garden parties particularly in the summer. Similar to findings on the previous inspection, one bathroom was located next to the 'mens' sitting room. The person in charge stated that this had now been assessed as to the impact on the privacy and dignity of residents who showered or had a bath in

this bathroom in the morning. She stated that there were controls in place with ensured that the risk to residents' privacy and dignity was assessed as low. There were a number of closed circuit TV (CCTV) cameras located in the centre. These were present in the hallways, smoking room and the three communal rooms. There was a CCTV policy in the centre, to support the use of CCTV. Signage was in place indicating the use of a CCTV camera. in each area of use.

Interactions between staff and residents with dementia were observed during the inspection. The inspector used a validated observational tool to rate and record at five minute intervals the quality of these interactions. The observation tool used was the Quality of interaction Schedule or QUIS (Dean et al 1993). These observations took place in communal areas. Each observation lasted a period of 30 minutes. During the first observation period the inspector noted that interactions were positive and meaningful. Staff members interacted with residents in a calm and relaxed manner. Residents were referred to by name. Staff members engaged in social conversation and encouraged residents to respond according to their abilities and capacity. According to the activity co-ordinator the activities for residents with dementia were designed to encourage and facilitate successful responses. Residents were seen to be enjoying the group interaction of card playing and individual interactions of physiotherapy, knitting, reading and watching TV. The overall evaluation of the quality of interactions during this period of 30 minutes was one of positive, connective care.

A second observation period was undertaken on day two of the inspection. Three residents with dementia, were sitting in one sitting room. The inspector found that they were unattended for the first ten minutes of the 30 minutes observation period. However, each resident was seated comfortably. For example, one resident had favourite objects next to him, on his chair. A second resident had her feet elevated, as set out in a care plan, seen by the inspector. This period of time was recorded as 'neutral' care. Staff then entered the room with residents' meal trays. Staff were seen to speak to each resident individually, before any support was offered. There was a calm atmosphere during the meal time, which provided a sense of positive wellbeing, for residents with dementia. The meal was unhurried and staff engaged in social conversation, with residents, throughout the period of observation. Residents were neatly and appropriately dressed, indicating a sense of respect for their dignity. Overall, the inspector found that the majority of interactions during the second observation period involved positive connective care.

Judgment:
Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

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

Findings:
Policies and procedures were in place for the management of complaints. Since the previous inspection the policy had been updated and contact details of the ombudsman had been made available. Records of complaints were reviewed by the inspector.

The satisfaction or not of each complainant had been documented in the records maintained in the centre.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
According to the person in charge and staff spoken with there were appropriate staff numbers and skill mix on duty to meet the assessed needs of residents. There were adequate staff numbers available for the size and layout of the designated centre according to the roster viewed by the inspector.

However, as discussed previously under Outcome 2: Safeguarding and safety a number of staff had not been afforded all mandatory training. In addition similar to findings on the previous inspection a large number of staff had not received the annual, mandatory fire training in 2016. This was significant as it was a repeat finding in a two-storey construction where vulnerable adults were accommodated on the upper floor. Furthermore, individual evacuation plans (PEEPs) had not been compiled for each resident to guide staff in the required evacuation technique. The person in charge stated that fire drills were undertaken. However, the records available were not sufficiently detailed to assure the inspector that evacuations and drills were undertaken by all staff, at suitable intervals to meet the needs of residents. For example, staff had not been involved in undertaking a simulated evacuation from the upstairs section of the building outside of the training session. All staff had not been afforded appropriate training in accordance to their role for example, infection control training, medication management training and manual handling training.

The inspector found that the centre was not in compliance with the centre's own policy on recruiting, selecting and vetting of staff and the centre's policy on the prevention, detection and response to abuse in relation to the recruitment and vetting of staff. For

example, in a sample of staff files viewed by the inspector Garda Siochana vetting was not in place for all staff on duty. The centre's policy stated "offers of employment shall be subject to satisfactory Garda clearance". In addition "gaps and inconsistencies in employment history" had not been adequately checked. The required number of references were not available in staff files. The policy in the centre stated that "offers of employment shall be subject to three satisfactory references which shall be followed up and verified".

The absence of Garda Vetting was in contravention of the requirements of the National Vetting Bureau Act 2012 and 2016. The inspector addressed this non compliance with regulations with the person in charge. The person in charge undertook to remove staff who did not have the required vetting clearance from the roster until Garda vetting had been received. In addition, the person in charge provided assurance to the Chief Inspector that all other staff on duty had Garda vetting in place. She also stated that in future no staff member would be employed without Garda vetting being in place, prior to employment.

The inspector found that the governance and management system in the centre was not in compliance with the regulations for the sector, specified in the introduction to this report. Similar to findings on the previous inspection, an annual review of the quality and safety of care had not been completed for 2015 and 2016. This was required under Regulation 23(d). The person in charge stated that she was aware of this requirement, as this had been identified as an action to be completed following the last inspection of 11 and 12 May 2016. At that time, the timescale for completion of the annual review had been identified by the provider as 31 October 2016. In addition, management meetings were not held. Minutes were not available and senior management staff confirmed with the inspector that there were no management meetings held to coordinate nursing and administration management in the centre, for example, staff supervision requirements such as, staff appraisals. Staff supervision arrangements were a requirement under Regulation 16 (b).

The personal identification numbers(PINs) of staff nurses in the centre were maintained.

Judgment:
Non Compliant - Major

Outcome 06: Safe and Suitable Premises

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 had been purpose-built as a nursing home. It was laid out over two storeys.

It was located in a scenic area surrounded by well tended and colourful gardens. The gardens were easily viewed through the large picture windows and residents, spoken with, expressed that they enjoyed the view. They spoke with the inspector about time spent in the garden when the weather was fine.

The design and layout of the centre promoted residents' independence and wellbeing. Storage facilities were generally adequate and were suitable for residents' belongings. The provider maintained a safe environment for residents' mobility, with handrails available in each hallway as well as assistive bars in showers and toilets. The decoration throughout was of a good standard and this was attended to on an annual basis. Adequate space was available to support residents' privacy. There was a variety of communal spaces available, including an indoor smoking room and oratory. At the time of inspection the centre appeared warm and comfortable.

The size and layout of bedrooms were suitable to meet the needs of residents. The centre had 28 single en-suite bedrooms, eight double en-suite bedrooms and two double rooms, which had toilet and shower facilities adjacent to the rooms. There were three sitting rooms, in the centre, including one located on the upper floor, which suited a number of residents with dementia as they had access to an area other than the bedroom for recreation, visiting and and meal times. Equipment was well maintained and service records were available.

Residents were generally positive in their comments in relation to the laundry arrangements and the linen cupboards were seen to be well stocked. Residents' wardrobes were observed to be tidy. Personal items were displayed around the home as well as in residents' bedrooms. Residents with dementia were seen to have personal items such as, personal bed linen, art work and photographs on display in the bedrooms. Residents' art work was also displayed on the walls of sitting rooms and on dressers. Art work was used to orientate residents with dementia to seasonal changes, for example, Easter art work was being prepared at the time of inspection.

Judgment:
Compliant

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:

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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:	Lystoll Lodge Nursing Home
Centre ID:	OSV-0000246
Date of inspection:	6 and 7 April 2017
Date of response:	25 May 2017

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 Registered Provider is failing to comply with a regulatory requirement in the following respect:
A resident who had been assessed as requiring monthly malnutrition universal screening tool (MUST) assessment, did not have this recorded on the care plan .

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

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

Please state the actions you have taken or are planning to take:
All residents are weighed monthly and this is documented in the residents care plan. However, since the inspection, we have developed a system that will allow a MUST assessment to be completed for all residents monthly. In the event of a resident becoming unwell, for example loss of appetite due to dementia, we weigh the resident on a bi-weekly basis and document our findings. We then engage with the GP and dietician.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had failed to ensure that care plans were accurately updated in accordance with residents' assessed needs.

2. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
A system is now in place to facilitate the PIC review care plans on a weekly basis on care which have been updated by our Nurses. This will ensure all residents assessed needs are accurately documented. This means that each nurse will identify several care plans each week that he/she will update. These care plans will then be reviewed by the PIC. This type of care plan review will mean that care plans are essentially updated in a contemporaneous manner.

Proposed Timescale: 30/09/2017

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:
Not all policies in the centre were implemented or adopted.
For example:
The policy on 'managing behaviour that is challenging' which was in place in the centre had not been fully implemented or adopted, in accordance with Regulation 4(1).
In addition, the requirements of the centre's policy on the prevention of abuse, in

relation to the recruitment and vetting of staff had not been met.

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

Please state the actions you have taken or are planning to take:
Following the inspection, we reviewed our staff induction. A checklist now ensures new staff receive a comprehensive introduction to the nursing home including vetting and all mandatory training. No staff will commence employment until Garda vetting is in place.
Training for all staff in managing behaviours is scheduled for June and July 2017.
Training for the prevention of, the detection of and the response to, elder abuse will be completed in May 2017.
An induction checklist devised since the HIQA inspection also ensures each staff member is familiar with the schedule 5 policies and mandatory training is completed and signed off by the PIC
The staff reviews will also highlight further training required.

Proposed Timescale: 31/07/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff in the centre had not been afforded training to update their knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging.

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

Please state the actions you have taken or are planning to take:
Training is scheduled for June/July 2017 to ensure all staff have up to date training and knowledge in managing behaviour

Proposed Timescale: 31/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All staff had not received training, in the centre, on the prevention of, the detection of and the response to, elder abuse.

5. 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:
As discussed with PIC at the inspection training on the detection and prevention of, and response to abuse, is arranged for two dates in May 2017 for all staff.

Proposed Timescale: 31/05/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on recruitment and vetting of staff was not adopted or implemented for all staff.

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

Please state the actions you have taken or are planning to take:
All staff currently employed have Garda vetting in place. All staff files are being reviewed to ensure all required records are in place.
Going forward all new Staff members will be vetted prior to commencement of employment.
Our checklist for new employees will ensure that all required records are in place and will be signed off by a member of management.

Proposed Timescale: 31/07/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had access to appropriate training in the centre:
For example:
Fire training
Fire drills
Medication management
Infection control
Manual handling

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:
Official fire training is undertaken annually, new staff receive fire training on induction, However, upon review, we will now conduct official annual fire training on a six-monthly rotational basis to accommodate newly recruited staff. This means that fire training for all staff is scheduled for June/July 2017. and will be carried out again in November and December 2017
Currently a personal fire evacuation plan is being devised for each individual resident which will be located in the residents' bedroom and a copy will be retained with the fire book. Fire drills and simulated fire evacuations will be undertaken quarterly and documented appropriately.

Training for medication management took place in October 2016, further training for Nurses will be completed in July 2017.

Manual handling was undertaken by a proportion of staff on 16/05/2017. Training for the remaining staff will be completed in June 2017. New staff will have manual handling training completed prior to commencement of employment.

In relation to infection prevention we updated all staff on the guidelines on infection prevention from the NDSC (National Disease Surveillance Centre) and sought advice from HSE Public health in University Hospital Kerry. We also developed and displayed posters to act as behavioural cues for hand hygiene for staff and visitors. In hindsight, this training should have been documented. In future, it will be.

The PIC will organise further training throughout the year as identified Training needs will be recognized through staff appraisals.

Proposed Timescale: 31/08/2017

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Management structures and roles and responsibilities were not clearly defined in the centre due to the absence of management meetings: for example: as regards responsibility for staff supervision and defining roles and responsibilities for members of the management team.
The annual review had not been completed.

8. 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:
Since the review, we hold weekly quality improvement meetings with management guided by the weekly collection of data to define management responsibilities for the coming week and going forward.

The annual review was completed following the inspection May 2017

Proposed Timescale: 31/08/2017

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All records required to be maintained under Schedule 2 of the regulations were not in place:
For example:
Garda vetting was not in place for a number of staff who were on duty or on the duty roster, at the time of the inspection.
The required references were not in place for all staff.
Inconsistencies and gaps in employment were not verified or available, for example not all staff had a CV (curriculum vitae) in place.

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

Please state the actions you have taken or are planning to take:
All staff on the duty roster have now been Garda vetted.
All new Staff members are Garda vetted prior to commencement of employment.
We are currently auditing staff files and will ensure all relevant records required are present in employee files.
A new employee checklist will ensure that all required records are in place for new staff in conjunction an offer of employment being made.

Proposed Timescale: 31/08/2017