<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Sheelin Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000160</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Tonagh, Mountnugent, Cavan.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>049 854 0414</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@sheelinnursinghome.com">info@sheelinnursinghome.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Sheelin Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Russell Mellett</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>PJ Wynne</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>31</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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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.

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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 13 February 2017 09:50  
To: 13 February 2017 18:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
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**Summary of findings from this inspection**

This report sets out the findings of an unannounced inspection, carried out by the Health Information and Quality Authority (HIQA). The centre can accommodate a maximum of 36 residents who need long-term care, or who have respite, convalescent or palliative care needs. Notifications of incidents received since the last inspection were reviewed on this visit.

The inspector reviewed progress on the action plan from the previous inspection. On the previous visit 14 outcomes were reviewed. Five outcomes were moderately non-compliant and seven outcomes were judged as substantially in compliance with the regulations. The majority of the actions were completed satisfactorily. However, further improvement was identified on this visit in some of the same outcomes.

HIQA received a notification of a change of person in charge in April 2016. The
person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. There is a manager working in the centre to oversee the governance, operational management and administration of the centre and to support the person in charge.

The premises, facilities, furnishings and décor were of a good standard. Staff interacted well with residents and in a respectful, responsive and appropriate manner. Staff demonstrated very good knowledge of residents’ needs, likes and preferred daily routine. The building was warm and comfortably decorated.

There was a good emphasis on personal care and ensuring the physical care needs of residents were met. The staffing levels on each work shift, skill mix and supervision arrangements were adequate to meet the needs of residents.

Aspects of the service identified for improvement in this report include,

Further development of systems to ensure good clinical governance is required. The system to review clinical risk assessments and care plans require review along with some of the fire safety precautions.
In line with national policy on promoting a restraint free environment (the use of bedrails) further work is required.
A number of staff were identified as requiring refresher training in fire precautions and safe moving and handling.

Thirteen outcomes were inspected. Three outcomes were non-compliant, moderate with the regulations. Three outcomes were judged as compliant with the regulations and seven as substantially in compliance with the regulations.

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National 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 Standards for Residential Care Settings for Older People in Ireland.

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
The statement of purpose detailed the aims, objectives and ethos of the centre. It outlined the facilities and services provided for residents and contained all information in relation to the matters listed in schedule 1 of the regulations.

The statement of purpose was revised in October 2016. The inspection evidenced the service provided was reflective and as described within the statement of purpose.

**Judgment:**
Compliant

<table>
<thead>
<tr>
<th>Outcome 02: Governance and Management</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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</tbody>
</table>

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

**Findings:**
There was a management structure in place with lines of authority, accountability and
responsibility for the provision of the service. The provider has a manager to oversee the governance, operational management and administration of the centre.

There is a system to review the quality and safety of care and quality of life in place. Audits were completed on the system to manage medicines. Key indicators were collected for example the number of admission and discharges and the dependency levels.

The purpose and objective of some audits completed requires review to ensure the audit leads to an improved outcome for residents. The falls audit requires review. While a post falls review was completed the review did not identify any possible contributory factor for example, changes to medication or onset of infection or clearly identify repeat falls by a resident.

Audits were completed to review the use of physical restraint management (the use of bedrails). While the use of bedrails was documented 17 residents have two bedrails raised. There was no review to determine if some residents only required one bedrail raised. The purpose and objective of some audits completed requires review to ensure the audit leads to an improved outcome for residents.

An annual report on the quality and safety of care was not complied with copies made available to the residents or their representative for their information as required by the regulations.

Support mechanisms require review to assist the person in charge manage the residential service and meet its stated purpose, aims and objectives. Further development of systems to ensure good clinical governance are required. The systems to develop, implement and review care planning requires improvement as discussed in Outcome 11, Health and Social Care Needs.

**Judgment:**
Substantially Compliant

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

**Findings:**
HIQA received a notification of a change of person in charge in April 2016. The person in charge is a registered nurse and is noted on the roster as working in the post full-
The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. The nominated person to fulfil the role of the person in charge has more than three years experience of nursing older persons within the last six years as required by the regulations.

During the inspection she demonstrated that she had good knowledge of the regulations and standards pertaining to the care and welfare of residents.

While she maintained her professional development, mandatory training required by the regulations was not maintained up to date. Refresher training in safe moving and handling techniques and fire safety was required.

She is supported in her role by an assistant director of nursing who had a good knowledge of each resident’s specific care needs.

**Judgment:**
Substantially Compliant

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

**Findings:**
Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were stored, maintained in a secure manner and easily retrievable.

Samples of records were reviewed by the inspector. These included records relating to fire safety, staff recruitment and residents' care, as well as the centre's statement of purpose.

A record of visitors was maintained. The directory of residents’ contained all information required by schedule three of the regulations and was maintained up to date.
details of the most recent transfer of a resident to hospital and admission to hospital.

A sample of staff files were reviewed. A record of current registration details for each nursing staff member was available. All the information required by Schedule 2 of the regulations was not available in each file examined. There were not two references available for some staff recruited in the past 12 months. One staff file did not have valid photographic identification.

Policies listed in Schedule 5 were in place, including those on health and safety of residents, staff and visitors, risk management, medication management, end of life care, management of complaints and the prevention, detection and response to abuse. Policies read had been reviewed by the person in charge and were maintained up to date.

The certificate of registration was displayed prominently as required by the regulations.

**Judgment:**
Substantially Compliant

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**Outcome 06: Absence of the Person in charge**
The Chief Inspector is notified of the proposed absence of the person in charge from the designated 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:**
The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days. This had occurred most recently in September 2016, when the person in charge was absent from the centre for a period exceeding 28 days.

The deputy notified to HIQA to deputise in the absence of the person in charge was available to meet the inspector on the day of inspection. They assisted with and facilitated the inspection.

**Judgment:**
Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
A policy and associated procedures for the prevention, detection and response to allegations of abuse was in place. There were sufficient numbers of suitably qualified staff on each shift to promote residents independence.

The inspector observed and saw that residents were treated well, with safety at the forefront of care. The inspector viewed records confirming there was an ongoing program of refresher training in protection of vulnerable adults.

No notifiable adult protection incidents which are a statutory reporting requirement to the HIQA have been reported since the last inspection.

Staff members spoken to had received training and understood how to recognise instances of abusive situations. They were aware of the appropriate reporting systems in place. Staff identified a senior manager as the person to whom they would report a suspected concern. Staff spoke confidently of being able to relay any issues and confirmed they are always listened to and their concerns are acted on.

During conversations with the inspector, residents confirmed that they were well looked after and they felt safe. Access to the centre was secured with a coded key pad.

Through observation and review of care plans it was evidenced staff were knowledgeable of residents’ needs. Staff provided support that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties.

There is a policy on the management of responsive behaviour. Staff had received training in responsive behaviours. However, care plans for residents with responsive behaviours and dementia were generic and described general good practice and not the specific needs of the resident. Care plan were not well personalised and did not explain triggers which may cause an altered pattern in mood or behaviour by a resident or the action to minimise any escalation in responsive behaviour.

There was a policy on restraint management (the use of bedrails and lap belts) in place. At the time of this inspection there were 17 residents with two bedrails raised. There was an improvement in the documentation to plan the management of the use of bedrails. The restraint assessment tool was reviewed in line with other risk assessments.
at regular intervals and each resident with a bed rail had an associated plan of care. While risk assessments and care plans were completed, they did not guide practice well. In some risk assessments completed all parts of the assessment form were not completed. While alternatives were trialled, the reviews did not state why other options were unsuccessful. In care plans the enabling function of the raised bed rail was not always clear or how it supported the resident was not outlined, for example, to help the resident sit up, turn in bed or as a psychological safety aid.

In line with national policy on promoting a restraint free environment further work is required. There was no review to determine if some residents only required one bedrail raised or continued evidence of exploring alternative less restrictive measures through audits and individual care plan reviews.

Judgment:
Substantially 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:**
Policies for infection control and prevention, absconding, incident reporting, smoking and fire safety with supporting protocols were also available and implemented in practice. There were policies and procedures in place for responding to major incidents to include serious disruption to essential services or the emergency evacuation of the centre if deemed necessary.

The action plan from the previous inspection to complete personal emergency evacuation plans for all residents was completed. These were collated in the fire register for ease of reference in the event of an emergency. Evacuation sheets were fitted to each resident’s bed.

Fire safety equipment was serviced quarterly and annually in accordance with fire safety standards. Fire exit signage was in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed around the building.

However, a review of some of the fire safety precautions is required; The fire policy did not provide sufficient guidance to reflect the centre's procedures of progressive horizontal evacuation.
There were procedures to undertake and record internal fire safety checks require review. The fire alarm was not activated regularly between servicing to ensure it was operational and automatic door closers were functioning correctly.

While fire exits were checked daily and the means of escape were unobstructed on the day of inspection, there was no documented checks on fire extinguishers to ensure they were in place and intact.

Thirteen staff were identified as requiring refresher training in fire safety. The person in charge had a training date scheduled as six staff did not have refresher training for a two year period.

Staff had not participated in regular fire drill practices. There were no records maintained of fire drill records detailing the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario.

There were procedures in place for the prevention and control of infection. Hand gels were located along the corridor. Audits of the building were completed at intervals to ensure the centre was visibly clean. There were a sufficient number of cleaning staff rostered each day of the week. There was a coded cleaning system to minimise the risk of cross contamination.

Training records evidenced that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents’ needs. Each resident’s moving and handling needs were identified in plans of care and changes communicated to staff at shift handover. The type of hoist and sling size required was specified in risk assessments.

Hand testing indicate the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to windows. Access to work service areas to include the kitchen and sluice room was secured in the interest of safety to residents and visitors. Access to stairwells was secured to mitigate risk to some residents. There was a lift to provide access to each floor of the building.

**Judgment:**
Non Compliant - Moderate

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**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
Findings:
There was a medicines policy and procedures in place. This included information on the prescribing, administering, recording, safekeeping and disposal of unused or out of date medicines.

There were no residents self medicating at the time of this visit. Medicines was dispensed from individual packs. These were delivered to the centre on a monthly basis by the pharmacist.

On previous inspections, the prescriptions sheets were transcribed by nursing staff. On this inspection medicine was dispensed from a copy of the original prescription. In some cases reviewed, there was ambiguity between the name of the medicine prescribed on the prescription and administration sheet. In some cases the generic name of the medicine was noted on the prescription and the brand name on the administration sheet. This may pose an increased a risk by using different names for the medicine between the prescription and administration charts.

The maximum amount for (prn) medicine (a medicine only taken as the need arises) was not indicated on all prescription sheets examined. The route via which the medicine is required to be administered was not indicated in all cases on the medicine charts. The person in charge had developed a new prescription and administration template. There are plans to implement these to record all medicine orders and administration detail for each resident's medicines.

Medicines that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift.

The pharmacist provided an education session to support medication management practice. However, advice from pharmacy of reviews of prescription kardex’s to guide nursing staff on contraindications and other forms of a medicine for those with swallowing difficulty or blood screening for residents on a particular drug over a prolonged timeframe was not evident.

Judgment:
Non Compliant - Moderate

Outcome 11: Health and Social Care Needs
Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/ her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/ her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The arrangements to meet residents’ assessed needs were set out in individual electronic care plans. There was evidence of nursing assessments using validated tools for issues such as falls risk, dependency level, risk of pressure ulcer formation and nutritional deficit. On admission a comprehensive assessment of needs was completed. Care plans were developed based on the assessments. The dependency of residents was regularly reassessed. This was an area identified for improvement in the action plan of the last inspection report.

The assessments were repeated if there was a change in a resident's condition. However, clinical assessments were not reviewed at the required four monthly intervals in each of the sample of files examined. Some risk assessments had not been reviewed for a six month period. Not all risk assessment in relation to each residents care were recorded in their electronic file. Some information was separate and did not allow for holistic care planning for example, moving and handling assessment and dependency level.

There were plans of care in place for each identified need. However, the interventions in some care plans were generic. The pre printed format did not ensure well personalised person centred care plans. The system to evaluate care plans requires review. Care plans were not always reviewed within the required timeframe and they did not contain the recommendations of allied health professionals following review of the resident in each case.

It was evident on this inspection residents had improved access to GP services. This was an area identified requiring improvement from the last inspection. There was evidence of medical reviews at least three monthly and more frequently when required. Newly admitted residents were seen by a GP within a short time of being admitted to the centre. The GP's reviewed and re-issued each resident's prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals including occupational therapist and physiotherapist was available to residents. There was evidence of reviews by the physiotherapist to promote mobility and improve respiratory function in files examined. There was evidence of seating assessments or specialist advise being obtained from an occupational therapist in the recent past.

There were two wounds being dressed and other minor skin issues being managed with protective dressings. There was evidenced based reporting as to the progress of the adequacy of the type and frequency of the care interventions, dressings applied and assessment of pain. There was access to a clinical nurse specialist in wound management. However, a review was not sought for one long term wound being
dressed.

There was a good range of specialist equipment provided for residents with an identified need. A number of residents were provided with air mattresses. Care staff completed repositioning charts for residents with poor skin integrity or when residents spent long periods of time in bed.

There was access to the psychiatry of later life team on referral by the GP. There was evidence in files of changes being made to antipsychotic medicine. However, further work is required to ensure ongoing monitoring following initial psychiatry review in the event of an acute episode to ensure optimum therapeutic values of psychotropic medicine prescribed and general wellbeing.

**Judgment:**
Non Compliant - Moderate

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**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):**
No actions were required from the previous inspection.

**Findings:**
The building is designed to meet the needs of dependent older people. The building was well maintained, warm, comfortably decorated and visually clean.

There was a call bell system in place and adequate storage was made available for residents’ belongings. The provider maintained a safe environment for residents’ mobility, with handrails in circulation areas and suitable floor covering.

Decoration throughout was of a good standard. All areas were well lit and heated. All bedrooms are en-suite with the majority fitted with a toilet and wash hand basin. Bedrooms were spacious. There was adequate space for the storage of clothing and personal belongings, including lockable storage for personal items. Privacy curtains were available in bedrooms accommodating two residents.

There were a sufficient number of toilets, baths and showers provided for use by residents. Toilets were located close to the day room for residents’ convenience. Each resident had sufficient space to store their clothing and personal belongings.
Staff facilitates were provided. Separate toilets facilitates were provided for care and kitchen staff in the interest of infection control.

A safe enclosed garden is available to residents.

**Judgment:**
Compliant

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**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:**
All residents were appropriately assessed for nutritional needs on admission and were subsequently reviewed regularly.

Records of weight checks were maintained on a monthly basis and more regularly where significant weight changes were indicated. However, the system requires review as there were gaps in some resident’s weight records and no explanation was recorded.

Residents spoken with were complimentary of the food and told the inspector they could have a choice at each mealtime. Requests for an option other than those on the menu were facilitated.

The instructions for foods and liquids that had to have a particular consistency to address swallowing problems were outlined in care plans and available to catering and care staff. There were a sufficient number of staff available to assist those requiring help. Assistance was offered in a discreet and respectful manner to residents.

The inspector observed mealtimes on each day of the inspection. There was a choice of a variety of well presented food. Portion were individually plated and generous in size. There was a high level of independence amongst the resident profile at mealtimes. Only four residents require full assistance with their meals.

There were detailed daily records maintained of each resident’s fluid intake. Food records were maintained for those identified with a nutritional risk. These specified the individual quantity consumed at each meal.

**Judgment:**
Substantially 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:**
There was evidence of a good communication amongst residents, the staff team and person in charge.

There was a good emphasis on personal care and ensuring the physical care needs of residents were met. Personal hygiene and grooming were well attended to by care staff. The inspector observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times.

Residents were able to exercise choice regarding the time they got up. Personal care was provided in bedrooms with doors closed. Breakfast took place at a leisurely pace throughout the morning until 11.00am.

On the last inspection, the role of the activity coordinator required review to ensure all residents have opportunities to participate in activities in accordance with their interests and capacities on a daily basis. This post was vacant at the time of this inspection. The inspector was informed that a person was recruited for the role but had not yet commenced. An activity on the day of inspection was provided after dinner in the dining room. However, a more structured approach to ensure meaningful engagement for residents throughout the day is required.

**Judgment:**
Substantially Compliant

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**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):**  
No actions were required from the previous inspection.

**Findings:**  
The inspector examined the staff duty rota, communicated with residents and relatives in relation to assessing staffing adequacy. During this inspection staffing levels on each work shift, skill mix and supervision arrangements were adequate to meet the needs of residents.

There were two nurses rostered each day from 8.00am until 5.00pm and one nurse each night supported by two care assistants. There are five care assistants rostered throughout the morning and four in the evening time. In addition there is catering, cleaning and administration staff employed.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. Staff had access to ongoing education and a range of training was provided. Mandatory training required by the regulations was facilitated on a rotational basis. As discussed in the report a number of staff were identified as requiring refresher training in fire precautions and safe moving and handling.

In addition to mandatory training required by the regulations, staff had attended training on infection control, nutritional care, cardio pulmonary resuscitation techniques and end of life care. Nursing staff were facilitated to advance their clinical skills and supported by management to engage in continuous professional development.

**Judgment:**  
Substantially 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:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual report on the quality and safety of care was not complied with copies made available to the residents or their representative for their information as required by the regulations.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:**
Family Questionnaires have been sent out on 15/03/2017, 6 have been returned. As soon as more have been returned to us we can compile the Quality & Care report.

<table>
<thead>
<tr>
<th>Proposed Timescale: 27/04/2017</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> Support mechanisms require review to assist the person in charge manage the residential service and meet its stated purpose, aims and objectives.</td>
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<tr>
<td>The purpose and objective of some audits completed requires review to ensure the audit leads to an improved outcome for residents. The falls audit requires review. Audits were completed to review the use of physical restraint management. There was no review to determine if some residents only required one bedrail raised.</td>
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<tr>
<td>The purpose and objective of some audits completed requires review to ensure the audit leads to an improved outcome for residents.</td>
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<tr>
<td><strong>2. Action Required:</strong> 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.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> 1. Interviews have been conducted and new Nursing staff will be employed to allow DON time off the floor and more time to manage the residential service. A monthly meeting will now take place between DON, ADON and senior carers to improve service. ADON will have scheduled days off the floor to support DON. 2. The Falls Audit will be reviewed after each incident with an aim to identify and highlight any contributory factors (ie,changes in medication/onset of any infection) which may lead to the accident. It also aids to identify residents who have repeated falls thus ensuring improved outcomes for residents and a decrease in incidents. The bed rail audit will also be reviewed along with supporting documentation to determine where residents require only one bed rail raised. They will show evidence where alternatives were trailed and their outcome. 3. Audits will be reviewed in a way that the purpose and process is evident, they will be supported with relevant documentation / assessments. The aims and objectives will be clearly identified ensuring better outcome for residents.</td>
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<td>Proposed Timescale: 1.01/05/2017</td>
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### Outcome 04: Suitable Person in Charge

**Theme:**
Governance, Leadership and Management

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The person in charge had not maintained mandatory training required by the regulations up to date. Refresher training in safe moving and handling techniques and fire safety was required.

**3. 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:**
Fire training has been completed on 03/03/2017, Elder Abuse 09/02/2017, Infection Control 09/02/2017, CPR AED 28/03/2017 and Manual handling training is scheduled April (dated to be confirmed by Iona College)

**Proposed Timescale:** 27/04/2017

### 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:**
All the information required by Schedule 2 of the regulations was not available in each file examined. There were not two references available for some staff recruited in the past 12 months. One staff file did not have valid photographic identification.

**4. 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 files are now updated with required Garda vetting, photo ID and references.

**Proposed Timescale:** 27/03/17 - completed

**Proposed Timescale:** 27/03/2017

Page 21 of 28
Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no review to determine if some residents only required one bedrail raised or continued evidence of exploring alternative less restrictive measures through audits and individual care plan reviews.

5. 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 / use of bed rail care plans will be person centred and purpose specific (ie, psychological safety, aid positioning). They will have detailed reviews and show continued evidence on alternatives and options trailed and the outcomes. Risk assessments will be carried out on all alternatives used. The bed rail audit will also be reviewed along with supporting documentation to determine where residents require only one bed rail raised. They will show evidence where alternatives were trailed and the outcome.

Proposed Timescale: 27/06/2017
Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans for residents with responsive behaviours and dementia were generic and described general good practice and not the specific needs of the resident. Care plan were not well personalised and did not explain triggers which may cause an altered pattern in mood or behaviour by a resident or the action to minimise any escalation in responsive behaviour.

6. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
New care plans to be introduced with a more person centred approach. Regular assessments relevant for Residents with dementia and challenging behaviours will be implemented to identify and highlight resident’s specific needs and the triggers that cause mood changes. We can then plan actions to minimise any escalation in
behaviour, these actions will detailed in their care plan. The care plans will reflect regular psychiatric input and reviews from community old age Psychiatric team.

Proposed Timescale: 27/06/2017

**Outcome 08: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The fire policy did not provide sufficient guidance to reflect the centre’s procedures of progressive horizontal evacuation.

The fire alarm was not activated regularly between servicing to ensure it was operational and automatic door closers were functioning correctly.

There were no documented checks on fire extinguisher to ensure they were in place and intact.

Thirteen staff were identified as requiring refresher training in fire safety. Six staff did not have refresher training for a two year period.

Staff had not participated in regular fire drill practices. There were no records maintained of fire drill records detailing the scenario or type of simulated practice, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to the simulated scenario.

**7. Action Required:**
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

**Please state the actions you have taken or are planning to take:**
1. Fire Policy has been reviewed to reflect the procedures of progressive horizontal evacuation.
2. The Fire Alarm is activated every Monday and same recorded. Additional checks are now in place to ensure fire doors are functioning correctly same are recorded along with the fire alarm.
3. Additional check is now in place to ensure and fire extinguishers are in place and are in service. This is recorded together with weekly fire alarm & fire door checks.
4. All staff are now up-to-date with fire training completed on 03/03/2017
5. Fire drills will now be scheduled once monthly, a report will follow out lining the scenario, response times of staff, staff action and performance of fire doors and other related equipment. An arrangement has been made for the Fire Training instructor to attend one fire drill.

Proposed Timescale: 1. 27/03/2017 – completed
2. 27/03/2017 – completed
Proposed Timescale: 27/04/2017

**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:**
In some cases there was ambiguity between the name of the medicine prescribed on the prescription and administration sheet. In some cases generic name of the medicine was noted on the prescription and the brand name on the administration sheet.

The maximum amount for (prn) medicine (a medicine only taken as the need arises) was not indicated on all prescription sheets examined.

The route via which the medicine is required to be administered was not indicated in all cases on the medicine charts

**8. 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:**
1. A new Kardex system has been introduced. Any ambiguity between brand name & generic name of medication has been eliminated.
2. The new Kardex system indicates all PRN medication separate from regular medications this includes the maximum dosage allowed.
3. The new Kardex system clearly indicates route, dose and frequency.

Proposed Timescale: 1. 27/05/2017
2.27/05/2017
3.27/05/2017

**Proposed Timescale: 27/05/2017**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Advice from pharmacy of reviews of prescription kardex’s to guide nursing staff on contraindications and other forms of a medicine for those with swallowing difficulty or blood screening for residents on a particular drug over a prolonged timeframe was not evident.
9. **Action Required:**
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

**Please state the actions you have taken or are planning to take:**
A meeting has been held with the Pharmacist with a plan to have a detailed medication audit. Pharmacist will be able to support the nurses by advising the contraindications, adverse effects, various forms of the medications and identify any resident who needs blood screening with particular drug over prolonged period. All advice from Pharmacist will be documented and recorded in each residents file.

**Proposed Timescale:** 27/05/2017

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**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans were not always reviewed within the required timeframe and they did not contain the recommendations of allied health professionals following review of the resident in each case.

Clinical assessments were not reviewed at the required four monthly intervals in each of the sample of files examined. Some risk assessments had not been reviewed for a six month period.

Not all risk assessment in relation to each residents care were recorded in their electronic file. Some information was separate from care plans and did not allow for holistic care planning for example, moving and handling assessment and dependency level.

10. **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:**
1. A schedule will be in place to ensure that all care plans are reviewed every 4 months or as required. After any review from allied health professionals the care plans will be supported by evidence of their recommendations,(ie,GP ,OT ,Physio, TVN,Old age psychiatry, dietian,SALT,ophthalmology,Dentistry and Audiology input)
2. A full suite of assessments along with a comprehensive assessment tool has been introduced and will be reviewed in the correct time frame or as directed.
3. All relevant assessments relating to resident care are now recorded in their file ie dietary information, manual handling assessment, risk assessments and dependency level.

Proposed Timescale: 1.27/06/17  
2. 27/06/2017  
3. 27/03/2017

**Proposed Timescale:** 27/06/2017

**Theme:**  
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was access to a clinical nurse specialist in wound management. However, a review was not sought for one long term wound being dressed.

Further work is required to ensure on-going monitoring following initial psychiatry review in the event of an acute episode to ensure optimum therapeutic values of psychotropic medicine prescribed and general wellbeing.

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

**Please state the actions you have taken or are planning to take:**
1. The services of a private TVN are now in place. All patients requiring review has been seen by the new TVN and also some have been reviewed by HSE TVN and have attended Ulcer clinics.
2. After an acute / repeated episode of challenging behaviour referrals are requested from the community old age psychiatric team to review the residents and their medications. These requests will now be escalated if they are not been reviewed in a timely fashion.
Regular 4 monthly medication reviews are in place for all residents and special cautions are given to those residents with dementia/challenging behaviour and the residents who take psychotropic medications.

Proposed Timescale: 1. 27/03/17 – completed

**Proposed Timescale:** 27/03/2017

**Outcome 15: Food and Nutrition**

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
There were gaps in some resident’s weight records and no explanation was recorded for same.

12. **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:**
A new weight monitoring tool has been developed. A graphical representation is in place which clearly shows any weight loss / gain. This tool highlights any action needed i.e SALT, dietician and allows for same to be recorded. Regular reviews will be in place to check any gaps in weight records and the same will be eliminated.

Proposed Timescale: 27/03/17 - completed

Proposed Timescale: 27/03/2017

**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:**
A more structured approach to activities to ensure a meaningful engagement for residents throughout the day is required.

13. **Action Required:**
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

**Please state the actions you have taken or are planning to take:**
The role of activities coordinator has now been filled since 20/03/2017. She works 4 days Monday-Friday (10-15:30). The fifth day alternates between Music Therapy, hairdresser and live Music.

Proposed Timescale: 27/03/17 - completed

Proposed Timescale: 27/03/2017

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A small number of staff were identified as requiring refresher training in safe moving
14. **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:**
Majority of staff now have up to date training. Fire training completed 03/03/2017, Elder Abuse 09/02/2017, Infection Control 09/02/2017, CPR AED 28/03/2017 and Manual handling training is scheduled April (dated to be confirmed by Iona College)

**Proposed Timescale: 27/04/2017**