

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Padre Pio Nursing Home
Centre ID:	OSV-0000267
Centre address:	Graiguenoe, Holycross, Thurles, Tipperary.
Telephone number:	050 443 110
Email address:	bmcnh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	B.M.C. (Nursing Home) Limited
Provider Nominee:	Lucie McCormack
Lead inspector:	Gemma O'Flynn
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	45
Number of vacancies on the date of inspection:	4

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 January 2017 09:15	17 January 2017 17:56
18 January 2017 07:00	18 January 2017 14:45

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

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

Summary of findings from this inspection

This report sets out the findings of an announced, two day inspection the purpose of which was to inform a registration renewal decision. The inspection also followed up on the actions that resulted following the centre's previous inspection in May 2016. Of the three actions two had been satisfactorily addressed. An action relating to fire drill practices required additional input by the provider to ensure full compliance was achieved. The provider demonstrated a commitment to achieving this.

Over the course of the inspection the inspector met with residents, relatives, staff and management. Practices were observed and documentation was reviewed. Overall, there was evidence that residents received care that was evidence based and of a good standard. Care was delivered by staff who demonstrated an in-depth knowledge of residents' needs and histories. Residents reported that they felt very safe in the centre and said that staff couldn't do more for them.

Based on the evidence seen over the course of the inspection, feedback from residents and relatives and conversations with staff, the inspector formed the judgment that the centre was in compliance or substantial compliance with the majority of the outcomes inspected against. Improvements were required in relation to documentation, particularly care planning and care documentation. Improvements were also required to ensure that the centre's practices in relation to use of restraint were fully in line with the national policy on restraint at all times.

The inspector's judgments in respect of compliance are set out in the table above and discussed in detail throughout the body of the report and in the associated action plan at the end of the report.

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

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose consisted of a statement of the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which were provided to residents. It contained all of the information required by schedule one of the regulations and was reviewed annually, most recently 29 September 2016. The inspector found that the statement of purpose was implemented in practice.

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There were sufficient resources to ensure the effective delivery of care as described in the statement of purpose. A record of refurbishment that had taken place in 2016 was provided to the inspector. Improvements such as new call bells, new bedroom furniture

for some bedrooms, new televisions and garden maintenance were some of the items recorded. Staff told the inspector that management were responsive to new ideas that would improve the lives of residents and suggestions for making technology available to residents had been approved via the purchasing of electronic devices that provided access to internet services. Equipment to provide safe care was seen to be available in the centre.

There was a clearly defined management structure in place. The provider was also the person in charge and she was supported by two clinical nurse managers. Staff were able to describe the management structure. Residents and relatives confirmed that the person in charge was a presence in the centre.

Management systems were in place to ensure that the service provided was safe and monitored. The person in charge demonstrated a commitment to ongoing improvements in the service provided. Audits were undertaken in hand hygiene, medical equipment, cleaning practices and care planning documentation. The inspector found that there was scope to improve these practices. For example, overall findings were not collated or compared to previous audit findings to ensure that audits were resulting in improvements in overall systems of care as opposed to remedying one aspect of one individual's care. Monthly falls audits were completed and elicited meaningful information, however, this required collation to ensure that improvements were achieved on an ongoing basis where possible. The inspector acknowledges that although a formal process of collation and analysis had not been applied, the person in charge was able to discuss findings at length with the inspector and inform of her plans to address same. Audit findings in relation to care plan documentation were not comprehensive as they had not identified issues observed on inspection. This was discussed in detail with the person in charge and supporting management staff.

An annual review of the quality and safety of care for 2016 was in the process of being completed. This included issuing a survey to relatives and residents and reviewed matters such as activities, food, management of complaints and satisfaction with staff. It also provided an opportunity to put forward suggestions for improvements. The responses resulted in a review of the survey format to ensure that going forward it would bring about more detailed and meaningful responses, including issuing it to short term stay residents. The person in charge stated that the annual review was completed from February to February annually and would include a full review of the quality and safety of care delivered to residents as required by the Regulations and would follow the format of the centre's annual review of 2015 which was available for inspection.

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: There was a guide to the centre available to residents displayed in the reception area. This document met the requirements of the regulations. Each resident had a contract of care and these were available for review. New contracts of care had recently been issued due to a change in the fee structure and the provider was awaiting on some of these to be returned. A system was in place to track these contracts to ensure that they were returned to the centre.</p> <p>Contracts of care set out all the fees being charged to the residents and included the services to be provided.</p>
<p>Judgment: Compliant</p>

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

<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: The person in charge was a qualified nurse and was suitably qualified and experienced manager in the area of health care. Her post was full time, she worked Monday to Friday 08:00hrs to 18:00hrs, one of those days being off site. Staff confirmed that the person in charge was available to them at all times and night staff who spoke with the inspector confirmed that the person in charge could be contacted at any time and there were occasions that she called to the centre outside of her core working hours.</p> <p>All staff, residents and relatives who spoke with the inspector confirmed that the person in charge was approachable and that they wouldn't hesitate in bringing any concerns to her attention. Staff reported that she was a responsive manager.</p> <p>In conversations with the inspector, the person in charge demonstrated an understanding of the legislation and sufficient knowledge of her statutory responsibilities. She demonstrated good clinical knowledge and seen to participate in morning handover. She was engaged in the governance and management of the centre</p>

on a regular and consistent basis.

Judgment:

Compliant

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Overall, complete records were maintained in the centre. However, some improvements were required to ensure that records, specifically care plans were kept accurately and up-to-date. This was discussed in detail with the person in charge over the course of the inspection. For example, care plans were not updated following review by an allied health professional, although a note was included in an evaluation section, this update was not always easily retrievable.

Some aspects of care plans were no longer relevant. For example, one care plan reviewed stated that a resident was prescribed PRN (as required) psychotropic medication to manage behaviour when in fact this medication had been discontinued. Other care plans as discussed in more detail in outcome 11 and 14 did not fully direct care nor reflect the detailed knowledge that staff were able to demonstrated during discussions with inspectors and observations of care interactions.

There was a policy in place for the retention of resident and staff records.

The policies required under scheduled five of the regulations were in place.

A directory of residents was maintained and met the requirements of the regulations.

Details of the centre's insurance policy was displayed in the reception area.

Judgment:

Non Compliant - Moderate

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

Theme:
Governance, Leadership and Management

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

Findings:
There had been no incidences whereby the person in charge had been absent for 28 days or more. The person in charge was supported by two clinical nurse managers who were appointed to deputise for any absence of the person in charge. These clinical nurse managers were in the centre on both days of the inspection and demonstrated good knowledge of the systems of care in the centre and of the residents' needs. They were involved in audits of care.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
There was a policy on, and procedures in place for, the prevention, detection and response to abuse. This had been reviewed in March 2016. Staff who spoke with the inspector demonstrated excellent knowledge of the different types of abuse and were very clear on their reporting responsibilities if they witnessed an incident of abuse or suspected abuse was taking place in the centre. All staff who spoke with the inspector indicated that there was a no tolerance approach in the centre and were aware of the reporting systems in place if any concerns arose regarding the person in charge in this regard. Records provided to the inspector indicated that staff had received the required training. Residents who spoke with the inspector said that they felt safe in the centre

and would speak to the person in charge if they had any concerns. The person in charge worked in the centre Monday to Friday and stated that she observed care practices throughout the day and ensured she was a presence in the centre. This was confirmed by the residents, staff and relatives.

There were systems in place to safeguard residents' money and records provided to the inspector were well maintained and easy to follow.

There was a policy in place for supporting residents who experienced responsive behaviours. Staff were observed interacting with and supporting such residents and were consistent in their approach. Staff who discussed effective management strategies to support residents were knowledgeable of triggers that may cause a resident to become distressed and outlined ways in which they could appropriately support the resident. Validated tools to monitor and track behaviours so as to identify trends and develop care appropriate to the resident were maintained. Referrals to external services were made where required and recommendations were implemented. However, as discussed in outcome 5 and 11, care plans did not reflect the knowledge of the staff and required development. For example, a care plan for a resident who was prone to physical outbursts did not clearly set out how to approach the resident. Ways in which to support the resident to eat their meal whilst supporting responsive behaviours required review as there was little or no guidance in the care plan document. This was discussed with the person in charge and clinical nurse manager over the course of the inspection.

Restraint was in use in the centre. Alternatives to restraint were also available such as low low beds and crash mats. The use of restraint was not always in line with the national policy on the use of restraint. For example, a care plan was not in place for the use of a lap belt and staff were inconsistent when discussing interventions to ensure safety whilst in use. Documentary evidence was available to demonstrate that medical and allied health input was sought in the decision to implement restraint. A risk balance assessment tool was completed for prior to the use of restraint. Records showed that hourly checks took place when bed side rails were in place. Approximately half of the residents in the centre had bed side rails in place. The use of restraint was not subject to audit to ensure practices were safe or to identify opportunities to reduce the incidence of restraint in the centre where appropriate. As discussed in outcome 12, the upstairs area in the centre and access to the enclosed garden were locked via a keypad to which only staff had the code. Therefore, residents who were physically and cognitively safe to do so could not access these areas without seeking staff permission. The person in charge was asked to review this practice to ensure it was proportionate.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

The centre had policies relating to health and safety. There was an up to date safety statement dated 24 June 2016. A risk management policy was in place, the person in charge took action on the day of inspection to ensure that it included the items specifically set out in regulation 26(1). There was a plan in place for responding to major incidents, this had been reviewed in March 2016. Risk assessments were documented in the safety statement and had been reviewed in May 2016. These included a trip hazard leading in to the dining room that had not been included in the risk assessment documentation on the previous inspection. Quarterly hazard inspections were completed and records were available for review.

Satisfactory procedures were in place for the prevention and control of healthcare associated infections. Key staff were knowledgeable as to what constituted an outbreak of infection and what steps to take should one so occur. Household staff who spoke with the inspector were well informed and described practices such as monthly deep cleans (at a minimum) of bedrooms and of the systems in place to prevent the spread of infection.

There were arrangements in place for investigating and learning from incidents and adverse events occurring in the centre. Controls were in place for identified risks.

Suitable fire equipment was provided and records were maintained for the servicing and inspecting of same. Fire exits were unobstructed on the days of inspection. Fire evacuation procedures relevant to staff and residents and visitors were displayed in the centre. Staff had received training and were able to demonstrate consistent knowledge on what to do if the fire alarm was to activate.

Fire evacuation drills were taking place as part of a structured training day with an external instructor. They had taken place in May, July, August and December of 2016 and documentation was available for review. Records of drills demonstrated the evacuation of one resident only. Therefore the inspector found that fire drill practices and documentation were insufficient to demonstrate that the arrangements for evacuation in the event of fire were fit for purpose. For example, fire drill records did not illustrate how long it would take to evacuate all residents from a specific compartment nor did they identify any issue that may have arisen such as additional training needs or staffing issues.

Judgment:

Substantially Compliant

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):

No actions were required from the previous inspection.

Findings:

There were written policies relating to medication management. These had been reviewed in November 2016. There were processes in place for the handling of medicines, including controlled drugs and staff were observed to follow appropriate medication management practices. Records for the administration and checking of controlled drugs were maintained and available for inspection. Staff were knowledgeable when asked questions pertaining to medication management. Prescriptions were transcribed and practices were seen to be in line with current guidance for nurses.

A log was maintained of medicines returned to the pharmacy including reasons for the return, a representative from the pharmacy also signed the returns books to confirm receipt of same. There were no residents who were self administering medication at the time of the inspection.

A list of residents prescribed psychotropic medications was maintained, the most update to date copy being week ending 31 December 2016. A medication audit was completed monthly.

Residents had a choice of two pharmacists and could also opt to retain the services of their own pharmacist if they so wished.

Judgment:

Compliant

Outcome 10: Notification of Incidents

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

A record of all incidents occurring in the designated centre was maintained. Notifications were submitted to HIQA within three days of the occurrence of any incident set out in paragraphs 7(1) (a) to (j) of schedule four of the regulations. A quarterly report was

also provided as required.

Judgment:
Compliant

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:

Overall, the inspector was satisfied that residents had access to medical and nursing care that met their needs on a daily basis. Improvements were required in the development of care plans to direct resident care.

Residents' health care needs were met through timely access to medical treatment. The person in charge stated that nine General Practitioners (GP) visited the centre. Residents had the option to retain their own GP or they could transfer their care to another if they so wished. Residents who spoke with the inspector confirmed that they saw their GP as required and said they were satisfied with the service they received if they had transferred their care.

A physiotherapist visited the centre weekly and they were involved in assessments of residents post falls or on admission. Physiotherapist input was also sought in the decision to utilise restraint, such as bed side rails, as evidenced in the sample of residents' files reviewed. Foot care was provided by a member of staff who contracted their services to the centre. Allied health services were accessible via local services upon referral. Evidence of reviews by allied health professionals such as speech and language therapists and tissue viability nurses was available in the sample of resident files reviewed. An optician service had visited the centre in October 2016.

Systems were in place to detect early signs of ill health. For example, residents were weighed monthly. If changes were noted, the frequency of weight checks were increased to weekly and input from dietician services was sought. There was documentary evidence of blood profiling and monthly checks of vital signs. Records indicated that residents were offered the annual influenza vaccine. Health promotion leaflets and posters were displayed in a circulation area.

Comprehensive assessments were completed for residents and included matters such as falls risk, skin integrity, nutritional status, oral cavity and continence assessment. Associated care plans were in place where required. Discussions with all grades of staff indicated that they were aware of residents' needs and the interventions required, however this knowledge was not always reflected in the residents' care plans. Overall, these directed care, however, improvements were required to ensure that care plans were person centred, were updated with advice from relevant health professionals and reflected the detailed knowledge of the staff.

For example, for a resident receiving wound care, documentary evidence indicated that care was received via the completion of the wound care chart that recorded the wound measurements and appearance. However, the care plan itself had not been updated once the resident had been reviewed by the tissue viability professional. The grade of the pressure sore was incorrectly recorded on the care plan.

A care plan for a resident at risk of dehydration required review to ensure that the information was accurately recorded. Nursing staff were consistent in their knowledge of the resident's need in this regard and the inspector observed that the appropriate interventions were implemented for this resident over the course of the inspection. Another care plan seen for a resident who had expressed dissatisfaction with their diet plan and whom had been swiftly referred to speech and language therapy had not been updated satisfactorily post review. These documentation issues are discussed further and actioned under outcome five.

Care plans had been reviewed four monthly as required by the regulations and there was documentary evidence that residents and relatives were involved in care plan discussions. Relatives who spoke with the inspector confirmed this.

Gaps were noted in some documentation relating to care given. For example, a care intervention prescribed to take place twice per week was not documented as having taken place as directed. Therefore, the inspector was unable to determine that the instruction was carried out as prescribed. This was discussed with the clinical nurse manager.

The inspector observed that care interventions were explained to the resident prior to carrying out care and permission was sought. Residents had the right to refuse care if they wished and documentary evidence demonstrated that this was respected.

Systems were in place to ensure that relevant information was provided about residents when they were absent or returned to the centre from another care setting or hospital. This information was retained in the residents' files.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose

and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

Overall, the inspector found that the design and layout of the centre were in line with the statement of purpose and meet the needs of the residents residing there. The premises and grounds were well maintained and on the day of inspection was seen to be well lit and ventilated and warm.

Homely fixtures and fittings were seen throughout and photographs of residents and their families were displayed all around the centre. Each wing had a floral theme and was named after a flower to assist residents in locating their bedroom area. Equipment to stimulate residents was incorporated throughout the centre. A large projector screen had recently been fitted in the day room. Wall games mounted in circulation areas, such as Tic Tac Toe, provided an opportunity for residents to engage in activity as they walked around the centre.

The centre was clean and free from odour on the days of inspection. Whilst overall the centre supported freedom of movement for the residents to use the common areas and their personal spaces, the upstairs wing was fitted with two door keypad locks. The person in charge explained that this was a safety feature due to the location of the stairs. However, no resident had access to the keycode and had to rely on staff for access and egress. The person in charge agreed to consider whether or not it would be appropriate and safe for residents assessed as being cognitively competent to have the code. (This is discussed further under outcome seven.)

There was good signage throughout the centre. Residents' bedroom doors had their names displayed on them and sometimes were accompanied by a photograph of the resident. Some residents were seen to personalise their bedroom doors with items meaningful to them.

Residents and relatives confirmed that there was sufficient space to store their belongings and a lockable storage unit was provided. There were wash hand basins in bedrooms that did not have full ensuite facilities. Hot water was available as seen by the inspector on the day of inspection. Each bedroom seen by the inspector contained the furniture required by the regulations. Shared bedrooms had privacy screening in place.

There was access to a safe enclosed garden. The person in charge said doors were open in the summer, however, on the days of inspection, these doors were locked and could

only be opened by a staff member. The person in charge was asked to review this arrangement to ensure that those who were assessed as being safe to do so could access the outside space without seeking permission from staff.

A working call bell was seen to be in operation and was answered in a timely manner. Toilet areas were accessible from bedroom and communal areas. Residents had access to equipment to assist with mobility and communication and staff were seen to utilise such equipment to assist residents. An oratory was available and seen to be used by residents. A dedicated 'pamper room' was also in place and was used for activities such as hairdressing services.

Handrails and grab rails were provided where required. A chair lift was in place between the ground and first floor, staff assisted all residents when using this equipment to ensure safety.

Judgment:
Compliant

Outcome 13: Complaints procedures

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

Theme:
Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There were policies and procedures for the management of complaints. The complaints process was displayed in the reception area and outlined in the residents' guide. The person in charge was the person nominated to deal with complaints. Records indicated that one complaint was received in 2016, the person in charge confirmed that this was accurate. The subsequent documentation gave a detailed account of the investigations and subsequent actions.

Residents said that they would not hesitate to make a complaint if they had one. Relatives said that they were very happy with the care and were aware of who they could complaint to if they needed to.

There was no nominated person separate to the person nominated in article 34(1)(c) who ensured that all complaints were appropriately responded to and records are kept. This was discussed with the person in charge in at the feedback meeting at the end of the inspection.

Judgment:

Substantially Compliant

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There were written operational policies in place for end-of-life care which staff were familiar with. They had last been reviewed in March 2016. The file of a recently deceased resident was reviewed and documentary evidence demonstrated that the care delivered to this resident had been audited in an effort to identify ways in which care could be improved. There was documentary evidence that discussions were had with the family of the resident to inform them of the resident's status.

Staff confirmed that they had access to community palliative care services and records indicated that appropriate medications to manage pain or associated symptoms were prescribed.

A priest visited the centre over the course of the inspection and anointed all residents who wished to receive same.

Staff discussed the ways in which respect was shown for the deceased resident such as displaying the end of life care symbol in the centre at times that residents were receiving such care. A guard of honour was provided by at least four members of staff when the remains of a resident were being removed from the centre.

An oratory was available in the centre for residents to pray and was seen to be used over the course of the inspection. Staff explained that residents were informed when another resident was deceased and were supported to pay their respects if they so wanted to.

Care plans and end of life wishes were reviewed and although they directed general care, they required development to ensure that they were person centred and reflected the detailed knowledge the staff held of the residents to ensure continuity of care could be provided at all times. This documentation issue is actioned under outcome five.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a comprehensive policy for the monitoring and recording nutritional intake which was put into practice. The policy was last reviewed in March 2016. Carers were allocated specific residents on a day to day basis and they monitored intake throughout the day and reported same to the nurse on duty. Intake was documented in the nurses' daily narrative notes and action was taken when a resident's fluid or food intake was not optimum.

There was access to fluids throughout the day and residents were offered assistance in discreet and sensitive manner. Approximately five residents chose to dine in the dayroom and those who spoke with the inspector said that this was their personal preference.

Special dietary requirements were addressed. A comprehensive file was kept in the kitchen outlining residents' nutritional needs and including speech and language therapist's reports. The cook spoke with the inspector and demonstrated in-depth knowledge of the residents' needs and preferences.

Food was properly cooked and prepared and was wholesome and nutritious. The person in charge confirmed that it had been reviewed by a dietitian in 2016 to confirm it was nutritionally balanced. Menus were displayed on the tables and these were complemented by pictorial menus which were seen to be offered to residents to describe the meals on offer. Pictures were used to describe different sized portions also available to residents.

Residents said they had sufficient choice and it was observed over the course of the inspection that residents felt free to express their personal choice at meal times. A vast menu was available for supper time meals. The cook prepared tasty home baking for residents.

An light snack options such as sandwiches was available after the supper meal if residents wished to have extra. Residents and relatives confirmed this.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents were consulted about how the centre was run. A residents' council convened quarterly as reflected by meeting minutes. There was documentary evidence that residents had an opportunity to put forward matters of concerns. Feedback was put in to practice such as menu suggestions. Residents also told the inspector that they could attend the meetings if they so wished and that they were useful events. Information relating to advocacy services was displayed in the lobby area and an independent advocate had attended a recent residents' meeting as per the minutes provided to the inspector.

Routines reflected residents' personal choices. In the sample of files reviewed information was recorded in the form of 'a key to me' and resident routine preference and expectations. Residents confirmed that they could dine when they chose and get up when they so wished. A relaxed atmosphere was observed over the course of the inspection. Residents told inspectors that they had the opportunity to vote in house if they so wished.

Religious needs were met in the centre. Mass was celebrated on the day of inspection and links with clergy of numerous faiths were in place if required. A monthly newsletter was devised and distributed to friends and families of residents in the centre bringing them up to date on the goings on in the centre. The centre had also recently set up a page on social media.

Communication boards were available in the day room to aid communication with residents where required. Staff were seen to utilise these devices over the course of the inspection. A communication booklet that contained prompts to aid effective conversation for those with communication difficulties was available in the reception area. There was ample communal space and residents were seen to relax whilst reading newspapers or engaging in their own hobbies such as knitting.

There was a seating area available for residents and their visitors and this was seen to be utilised. Residents' preferences regarding visiting arrangements were documented in the meeting minutes and seen to be respected and implemented. A cordless telephone

was available to residents if they wished to use it.

Staff interactions with residents were seen to be respectful at all times. It was evident that staff across all grades knew residents well. Staff were seen to stop and chat with residents as they passed by and care interventions were explained prior to delivery.

An activities coordinator was on duty seven days per week and a comprehensive activities schedule was in place. Activities included exercises, cinema day, card game, therapeutic activities tailored towards residents with a dementia, outings and beauty sessions. Residents were seen to engage in these activities in good numbers and appeared to enjoy what was on offer. Residents with a dementia were seen to be included and those who did not wish to partake in group activity were seen to participate in smaller groups or one to one activity. Electronic devices were available for residents to access internet services if they so wished.

Residents were supported to maintain links with the community by attending local support groups.

Judgment:

Compliant

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy on residents' personal property and possessions and property lists were seen in the sample of residents' files reviewed. Residents and relatives said they had ample space for belongings and clothes that were laundered in the centre were always returned to them. Residents and relatives who had special requests for clothes requiring laundering to be returned to family said that this request was facilitated.

Judgment:

Compliant

***Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have***

up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

There were sufficient staff with the right skills, qualifications and experience on duty over the course of the inspection to meet the assessed needs of the residents. Copies of rosters given to the inspector indicated that these were normal arrangements with the exception of one carer who had had been scheduled as an extra resource to relieve colleagues if needed over the course of the inspection.

On the days of inspection there were 43 residents residing in the centre, two of whom were in hospital. Resident dependency levels had been assessed and determined that 17 residents had maximum dependency, 9 had high dependency, 11 had medium dependency and 6 had low dependency needs. In addition to the person in charge who worked Monday to Friday 08:00hrs to 18:00hrs, there were three nurses scheduled on daily duty, two nurses 08:00hrs to 20:00hrs and one nurse 08:00hrs to 18:00hrs. Carers were rostered on 08:00hrs to 20:00hrs shifts; 08:00hrs to 18:00hrs shifts; 07:00hrs to 14:00hrs and 08:00hrs to 14:00hrs. Staff who spoke with inspectors confirmed that staff levels were more than sufficient as did residents and relatives. Catering staff worked 08:00hrs to 18:00hrs. There were two household staff Monday to Friday and one household staff at the weekend. Laundry staff were also in place. There were two activities coordinators who between them covered Monday to Sunday. The person in charge was also supported by administrative staff.

A comprehensive staff handover was observed at the commencement of the day shift on the second morning of the inspection. This included updates on residents who had recently returned from hospital. A member of staff confirmed to the inspector that this was standard procedure. A number of staff told the inspector that a weekly bulletin was also posted on a notice board in the centre for staff to refer to. It contained updates on any important issues that had occurred in the centre in the previous week.

Staff reported that the person in charge had a proactive approach to training and was committed to the professional development of her staff. Records demonstrated that staff were up to date with mandatory training and had also received additional training such as training in dementia care which the person in charge stated incorporated training in responsive behaviours. Nursing staff reported that they had access to training to develop clinical skills such as venepuncture, wound management and male catheterisation.

Staff were appropriately supervised. Annual appraisals were conducted as per documentary evidence. There were effective recruitment processes in place. Interviews consisted of a questionnaire to determine competency and staff discussed the induction programme for new staff which included a period of time where the new recruit was supernumerary. The requirements of schedule two of the regulations were in place in the sample of staff files reviewed as were up-to-date registration with relevant professional bodies. A vetting disclosure was in place in all files reviewed and the person in charge gave verbal assurances that all staff working in the centre had a vetting disclosure in place.

The person in charge stated that there were no volunteers in the centre at the time of inspection. Volunteer agreements were on record for previous volunteers from a local school.

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:

Gemma O'Flynn
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Padre Pio Nursing Home
Centre ID:	OSV-0000267
Date of inspection:	17/01/2017
Date of response:	10/02/2017

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Audits required development to ensure they were comprehensive and to collate and analyse findings to identify overall trends that would lead to overall improvements in systems of care.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The PIC endeavours to review and streamline all aspects of audits to ensure that it contributes to improved outcomes of care. The PIC will analyse and collate audits on a quarterly basis to ensure that necessary improvements are identified and implemented.

Proposed Timescale: 31/03/2017

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:

Improvements were required to ensure that records, specifically care plans, were kept accurately and up-to-date.

2. 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:

The Care plans referred to by the Inspector have been reviewed and updated to ensure that they are accurate and person-centred. The PIC in consultation with Nursing and Care Staff will undertake a review of each Resident's care plan to ensure that they are accurate and up-to-date.

Proposed Timescale: 15/04/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Care plans to support residents with responsive behaviours did not reflect the knowledge of the staff and required development to ensure that they fully directed care.

3. 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:

The PIC in consultation with Nursing and Care Staff will undertake a review of care plans of each Resident with Responsive Behaviours to ensure that they accurately reflect the care being delivered.

Proposed Timescale: 15/04/2017

Theme:

Safe care and support

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

The use of restraint was not always in line with the national policy on the use of restraint. For example, a care plan was not in place for the use of a lap belt and staff were inconsistent when discussing interventions to ensure safety whilst in use.

The upstairs area in the centre and access to the enclosed garden were locked via a keypad to which only staff had the code. Therefore, residents who were physically and cognitively safe to do so could not access these areas without seeking staff permission. The person in charge was asked to review this practice to ensure it was proportionate.

4. 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:

The PIC will ensure that restraint is used in line with National Policy. The aforementioned care plan has been reviewed and a care plan has been initiated for the use of a lap belt. The PIC will review the current use of bedrails and the use of bedrails will be incorporated into our audit schedule.

The PIC will ensure that Residents who are deemed physically and cognitively safe will be provided independent access to the enclosed garden. Two Residents have been identified as being physically and cognitively safe to independently access the garden at this time. These Residents have been provided with the key pad code to independently access the garden. As per Regulation 26(1)(a)(b) – “The registered provider shall ensure that the risk management policy set out in Schedule 5 includes, the following: (a) hazard identification and assessment of risks throughout the designated centre; (b) the measures and actions in place to control the risks identified.”

As per the Risk Assessment undertaken as part of our Safety Statement, the stairs have been deemed to be a high-risk area. We therefore believe that the use of key pads is proportionate to the risk.

Proposed Timescale: 28/02/2017

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:

Fire drill practices and documentation were insufficient to demonstrate that the arrangements for evacuation in the event of fire were fit for purpose. For example, fire drill records did not illustrate how long it would take to evacuate all residents from a specific compartment nor did they identify any issue that may have arisen such as additional training needs or staffing issues.

5. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

The PIC will contact the independent fire safety training officer to ensure that documentation of fire drill practices specify compartments evacuated, length of time taken for evacuation, and identify any issue that may have arisen such as additional training needs or staffing issues.

Proposed Timescale: 28/02/2017

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:

Gaps were noted in some documentation relating to care given. For example, a care intervention prescribed to take place twice per week was not documented as having taken place as directed. Therefore, the inspector was unable to determine that the instruction was carried out as prescribed.

6. Action Required:

Under Regulation 06(2)(b) you are required to: Make available to a resident medical treatment recommended by a medical practitioner, where the resident agrees to the recommended treatment.

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

The PIC has reiterated to Nursing Staff the importance of ensuring that all care interventions are accurately documented once completed. The PIC will review

compliance in this area as part of ongoing audit schedule.

Proposed Timescale: 20/01/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

There was no nominated person separate to the person nominated in article 34(1)(c) who ensured that all complaints were appropriately responded to and records are kept.

7. Action Required:

Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

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

The PIC has nominated a person separate to the person nominated in article 34(1)(c) who will ensure that all complaints are appropriately responded to and records are kept.

Proposed Timescale: 20/01/2017