Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	St. Teresa's Nursing Home
Centre ID:	OSV-0000293
Centre address:	Friar Street, Cashel, Tipperary.
Telephone number:	062 61 477
Email address:	c.carestipp@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Cashel Care Limited
Provider Nominee:	Michelle McCormack
Lead inspector:	Vincent Kearns
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	27
Number of vacancies on the date of inspection:	3

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 compliance with National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
05 April 2017 07:30	05 April 2017 17:00
06 April 2017 07:30	06 April 2017 16:00

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

Outcome	Our Judgment
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of a two day unannounced inspection, in which 10 outcomes out of a possible 18 outcomes were reported upon. The purpose of the inspection was to monitor on-going compliance with the Care and Welfare Regulations and the National Standards. St Teresa's Nursing Home was registered to provide accommodation for 30 residents. The centre was originally built as a Presentation convent in the mid 1800's and was established in 2000. It is located on a large private 2 acre site in the centre of Cashel town and consists of a three-storey limestone structure that has been extensively refurbished. Residents are accommodated on the first and second floors and generally the design and layout of the premises is reflective of the period in which it was built.

As part of the inspection process, the inspector met with residents and their representatives, staff members, the recently appointed person in charge and the provider. The inspector observed practices and reviewed documentation such as policies and procedures, care plans, medication management, staff records and accident/incident logs. Residents told the inspector that they were happy living in the

centre and that they felt safe there. Overall the findings of this inspection indicated that residents received care to a good standard. Most staff were able to demonstrate good knowledge of the residents' care needs when speaking with the inspector. However, following this inspection the provider was requested to provide the Authority with action plan within 5 days in relation to significant failings identified including:
1. unsafe medication management and practice
2. the absence/inadequate care plans particularly in relation to respite residents
3. the lack of risk assessments for residents who smoke tobacco
4. the absence of notifications to the chief inspector in relation to changes of the person in charge
5. the absence of contracts for respite residents
6. the inadequate records for fire safety evacuation drills, fire alarm system and emergency lighting.

A satisfactory response in relation to this immediate action plan was received by the Health Information and Quality Authority (HIQA).

From the 10 outcomes reviewed during this inspection; one of the outcomes was compliant and three outcomes substantially compliant with the regulations. However, the following three outcomes were deemed to be moderately non-compliant; information for residents, health and safety and risk management and suitable staffing. In addition, there were three outcomes found to be at major non-compliance; absence of the person in charge, medication management, and, health and social care needs. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

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

Theme:
Governance, Leadership and Management

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

Findings:
There was a guide to the centre available for residents that included a summary of the services & facilities available, the terms and conditions of residency, the procedure respecting complaints and the arrangements for visits.

The inspector reviewed a sample of contracts of care that were in place. However, not all contracts of care reviewed contained details as required by regulation including the following details:
● the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned,
● the fees, if any, to be charged for such services
● the terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, "after" the terms.

In addition, the inspector noted the three residents recently admitted to the centre for respite care did not have a contract of care agreed in writing on admission to the centre.

Judgment:
Non Compliant - Moderate

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
There was a full-time person in charge who was a registered nurse with the required experience and clinical knowledge in the area of nursing older people. Throughout the two days of inspection the person in charge demonstrated an adequate knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. The person in charge had only started working in the centre two days prior to this inspection however, she was able to demonstrate good clinical knowledge of the residents in the centre and had sufficient knowledge of the legislation and her statutory responsibilities. Residents who spoke with the inspector were able to identify her as the person in charge and told the inspector that staff were supportive in providing care. Staff to whom the inspector spoke were positive in their feedback regarding the new person in charge and told the inspector that thus far she was approachable as a manager. The inspector noted that the person in charge also demonstrated a positive approach towards meeting regulatory requirements and a commitment to improving standards of care.

On the first morning of the inspection the person in charge informed the inspector that she had just commenced working in the centre two days previously on Monday 3 April 2017. The inspector was informed that the previous person in charge had left the centre in October 2016. However, there had been no notification by the provider representative to HIQA as required by regulation in relation to the previous person in charge leaving. In addition, there had been no notification to HIQA in relation to the new person in charge commencing in the centre. This issue was actioned under outcome 4 of this report.

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:
There were centre-specific policies that generally reflected the centre's practices and records were kept securely and were easily retrievable. However, a number of policies had not been update/reviewed as required by regulation for example the policy in relation to the use of restraint was last reviewed in December 2013, the policy in relation to the transcriptions of medications was dated as last reviewed in April 2013 and the policy on the management of records was dated as being reviewed in January 2013.

The records listed in Schedules 2,3 and 4 of the Regulations were in place; however there were occasions whereby the resident's care plans required further development to fully reflect the centre's practice and the knowledge of the staff. For example, the care plan for a resident with specific elimination needs required some additional information to fully guide staff. The care plan for another resident with specific mobility needs, required further information regarding the number of staff required to assist with a transfer.

Documentation relating to fire drill practices required development. It was not clear what issues had arose during the drill and therefore records did not enhance learning opportunities to assist with improving staff and residents' responses to fire drills. This was discussed in further detail under outcome 8. The centre was adequately insured as required by the Regulations.

Judgment:
Substantially Compliant

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:
On the first morning of the inspection the person in charge informed the inspector that she had just commenced working in the centre two days previously on Monday 3 April 2017. The inspector was informed by the provider representative that the previous person in charge had left the centre in October 2016. However, there had been no written notification to HIQA in relation to the absence of the previous person in charge or the current person in charge. HIQA had not been provided with details in relation to the procedures and arrangements that were to be in place for the management of the centre during the absence of the previous person in charge. The provider representative had not given notice in writing to the Chief Inspector of the arrangements that had been, or were proposed to be, made for appointing another person in charge to manage

the centre, including the proposed date by which the appointment was to be made as required by the regulations.

Judgment:
Non Compliant - Major

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

Findings:
The person in charge confirmed that there was no active reported, suspected or alleged incident of abuse in the centre. The newly appointed person in charge informed the inspector that she was actively engaged in the operation of the centre on a daily basis. The inspector viewed policies and procedures for the prevention, detection and response to abuse and noted that this policy had been reviewed in February 2017. Staff to which the inspector spoke with were able to confirm their understanding of the features of elder abuse and their reporting obligations. Staff outlined for example their on-going "vigilance" and their confidence that the provider representative and the person in charge would take appropriate action if and when required.The inspector noted from staff files that elder abuse training had been provided. However, from a review of the staff training records most but not all staff had received up-to-date training all in a programme specific to protection of older persons and one staff had yet to receive elder abuse training.

The inspector saw that there was a positive, respectful interactions and an easy rapport between staff and residents. Some residents were comfortable in asserting themselves and bringing any issues of concern to the person in charge. Residents and relatives spoken to articulated that they had confidence in the staff and expressed their satisfaction in the care being provided.

In relation to residents' financial transactions the centre maintained day to day expenses for a small number of residents and the inspector saw evidence that financial records were maintained. The inspector reviewed with the provider representative the system in place to safeguard residents' finances which included a review of a sample of records of monies and noted that there were adequate arrangements in place. While there was no formalised audit system in place the provider representative informed the inspector that he would instigate a formal audit system in relation to this small number of residents

financial records.

There was evidence that residents who presented with behaviours that challenge were reviewed by their General Practitioner (GP) and referred to other professionals for review and follow up as required. The inspector saw evidence of some positive behavioural strategies were in place and staff spoken to outlined suitable practices to prevent responsive behaviours. There was a policy on behaviours that challenge signed and dated as reviewed in May 2015. Most staff had been provided with training in the centre on behaviours that challenge. However, while further training was planned training records evidenced that not all staff had not received up-to-date training in this area.

There were 10 residents using bedrails on the day of inspection and the inspector was assured by the practices in place and saw for example that alternative measures such as low profiling beds were being used to reduce the use of bed rails, when possible. The person in charge stated the there was a commitment to a restraint free environment however, the policy on restraint required review as it was last reviewed in December 2013, this issue is actioned under outcome 5. There was evidence that the use of restraint was generally in line with national policy. The inspector saw that there was a comprehensive assessment form in place for the use of restraints however, from a review of a sample of care plans not all residents with bed rails in place had this assessment completed.

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:
The fire policies and procedures were centre-specific. The fire safety plan was viewed by the inspector and found to be adequate. Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were placed in prominent places throughout the building. The internal and external premises and grounds of the centre appeared safe and secure, with appropriate digital locks installed on all exterior doors and a register of all visitors to the centre was maintained. Staff demonstrated an appropriate knowledge and understanding of what to do in the event of fire and were familiar with what actions to take in the event of a fire alarm activation, and with the principles of horizontal evacuation. Staff fire training was provided however, most but

not all staff had up to date fire training as required by regulation. Completed logs were maintained on fortnightly checks of fire equipment, doors, exit routes and emergency lighting and all fire exits were noted to be free of any obstructions. However, the door leading into the small sitting room was wedged open by a small table, the main entrance door into the centre was wedged open by a large potted plant and there was a running man sign pointing to an exit in the conservatory that was locked and no longer in use. The person in charge confirmed that some residents smoked tobacco.

A policy was in place and reference the requirement for risk assessments to be completed however, not all residents had been individually risk assessed in relation to their capacity to smoke tobacco safely. Certification of testing and servicing of extinguishers and the alarm system were documented with the most recent recorded in March 2017. There were also records of such servicing was completed on a quarterly basis there for the previous three quarters. There were personal emergency egress plans (PEEPs) for all residents which identified the level of mobility and evacuation mode of each resident. Practiced fire drills were held, that included simulation of an actual evacuation to determine the competency of staff to use evacuation equipment such as evacuation sheets. The most recent fire drill was recorded as occurring in January 2016. However, such records of the practiced drills, were not available for review and were conducted annually and not biannually as required. Records of the fire drills were not available on the day of inspection of the actions taken and outcome of the fire drill, therefore there was no record of learning from the drill or any improvements required as a result. Due to the design, size and layout of the building over three floors, regular fire drills at different times of the day in each floor would be required. The person in charge acknowledged that fire drills needed to be undertaken more frequently.

There was a centre-specific emergency plan that took into account emergency situations and where residents could be relocated to in the event of being unable to return to the centre. Clinical risk assessments were undertaken, including falls risk assessment, assessments for dependency, assessments for malnutrition and assessments for pressure ulcer formation. The provider had contracts in place for the regular servicing of all equipment and the inspector viewed records of equipment serviced which were up-to-date. There were reasonable measures in place to prevent accidents such grab-rails in toilets and handrails on corridors and safe walkways were seen in the garden areas. Accidents and incidents were recorded on incident forms and were submitted to the person in charge and there was evidence of action in response to individual incidents. However, accident reports were not comprehensively completed and there were a number of sections of these accident reports that were left blank. For example in some accident reports there were sections regarding contacting the family, contacting the General Practitioner (GP) or details of clinical observations noted following an accident that were left blank.

The inspector spoke to staff that worked in the laundry and the handling and segregation of laundry was in line with evidence based practice. Vinyl latex gloves and plastic aprons were located throughout the centre and staff confirmed that they used personal protective equipment such as latex gloves and plastic aprons as appropriate. However, the training matrix indicated that not all staff had completed training in infection prevention and control and this issue was actioned under outcome 18 of this report. The communal areas and bedrooms were generally found to be clean and there

was adequate standard of general hygiene at the centre. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and most staff that were interviewed demonstrated knowledge of the correct procedures to be followed. However, not all staff interviewed were adequately knowledgeable in infection prevention and control or demonstrated suitable hand hygiene practices. Deep cleaning schedules ran in tandem with the daily cleaning however, there were gaps noted in the daily cleaning schedules particularly at weekends when the cleaner was off duty. In addition, the inspector noted a number of large containers of ointments and creams stored in a public areas without any residents' identifying details.

The health and safety statement seen by the inspector was centre-specific and the health and safety policy was recorded as being most recently reviewed in September 2016. There was a risk management policy as set out in schedule 5 of the regulations and included most of the requirements of regulation 26(1). The policy did cover, the identification and assessment of risks and the precautions in place to control the risks identified. However, the risk management policy did not include the measures and actions in place to control the following specified risks, 1) the unexplained absence of a resident, 2) accidental injury to visitor or staff, and 3) aggression and violence.

There was a risk register available in the centre however, the inspector found that the hazard identification process was inadequate. On the days of inspection, a number of potential hazards were identified by the inspector that had not been risk assessed including:
● the stair banisters in the centre had not been risk assessed
● there was unrestricted access to two sluice rooms that contained various cleaning agents and chemicals
● the storage of latex gloves and plastic aprons were potentially hazardous to any resident with a cognitive impairment
● there was no call bell in the conservatory
● access any resident with a cognitive impairment to the lift
In addition, the design and layout of the two sluice rooms required review as there were unsuitable items stored in one sluice room including a large container of paint, painting roller brush and pole, the frame of a large waste bin and a assistive equipment. In addition, there was no suitable racking for storage of urinals and the sluicing sink was not suitable to prevent spillages/splashes.

Judgment:
Non Compliant - Moderate

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:
The inspector reviewed a number of medication prescription charts and noted that most included the resident's photo, date of birth, general practitioner (GP) and details of any allergy. Medication administration sheets identified the medicines on the prescription sheet and allowed space to record comments on withholding or refusing medications. The inspector noted that there were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents however, this policy was not up-to-date as it was last reviewed in February 2013. This issue was addressed under outcome 5 of this report. In addition, the inspector noted that there was a large bottle of an anti-constipation medication was stored on the medication trolley however, it did not contain any residents prescription label.

Medicines for residents were supplied by a community pharmacy. Nursing staff with whom the inspector met outlined an adequate procedure for the ordering and receipt of medicines in a timely fashion. Medication trolley was secured and the medication keys were held by the staff nurse on duty. The inspector observed a nurse administering the lunch time medications on the second day of the inspection however, this was not carried out in line with best practice. For example the inspector observed that there was a meal serving tray with empty dinner plates. However, there were also three medication containers with slips of paper containing residents names placed in each container on this tray. The inspector noted that one medication container had a crushed white tablet. This unsafe practice of "potting" medications was confirmed by staff to whom the inspector spoke with and was not in line with An Bord Altranais and Cnáimhseachais na hÉireann guidance to Nurses and Midwives on Medication Management (2007). In addition, the inspector observed that this potted medication had been left unsupervised on a windowsill on the first floor bedroom corridor in the centre. The person in charge confirmed to the inspector that such practices would immediately stop.

There were appropriate procedures for the handling and disposal of unused and out of date medicines and the documenting of same. Medicines requiring refrigeration were stored in a medication fridge and the temperature of the medication refrigerator and storage areas was noted to be within an acceptable range. The temperature was monitored and recorded daily. The inspector noted that this fridge contained insulin however; this fridge was unsuitably stored as it was easily accessible and unsecured.

The practice of transcription of medication was not in line with the centre-specific policy and guidance issued by An Bord Altranais agus Cnáimhseachais for all prescriptions seen. Transcribed prescriptions were not always signed by a second nurse who independently checked the prescriptions or cosigned by the prescriber within 72 hours. In addition, one resident that had been admitted the previous night and had brought their own medications into the centre had received their medication that morning prior to their prescription being completed by the GP. The person in charge did confirm that the GP had completed the prescription for this residents' medication shortly after this matter had been highlighted.

Controlled drugs were stored in accordance to best practice guidelines and nurses were checking the quantity of medications at the start of each shift. The inspector did a count

of controlled medications with the nurse which accorded with the documented records. However, the inspector noted that there were some co-signing gaps in the records for controlled medications.

There was a system in place for reviewing medications on a three monthly basis by the GP and pharmacist and this was documented in residents' notes. The inspector saw that some residents required their medications in an altered format such as crushed medications. However, not all medications that required crushing were seen to be prescribed as such for each individual medication that required crushing. Therefore nursing staff were administering medication to residents in crushed format although it had not been specifically indicated on the prescription sheet.

Judgment:
Non Compliant - Major

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 each resident's wellbeing and welfare was maintained by an adequate standard of evidence-based nursing care and appropriate medical and allied healthcare. At the time of inspection there were 27 residents living in the centre and staff had assessed the level of residents' dependence in their activities of daily living as follows; two rated as low, nine as medium, five as high and 11 as maximum dependency level. This equated to the majority (60%) of residents as being assessed as high to maximum dependency level.

There was evidence that timely and appropriate access to medical review and treatment was provided and was supported by the medical records seen by the inspector. There was documentary evidence of adequate access to other health professionals including speech and language therapy, dietetics optical review and chiropody. The inspector observed that a number of residents required transferral to and from the centre. Adequate referral and discharge records and records of the information provided when a resident was temporarily transferred or discharged from the centre were maintained.

There were measures identified in falls prevention care plans and evidence of falls being monitored in the centre. There were reassessments of some falls risks and the updating

of some but not all the falls prevention care plans by staff after each fall. Falls were reviewed individually to identify any possible antecedents or changes as appropriate. The inspector was satisfied that staff spoken with were familiar with each resident's needs and care plans. That overall few deficits were identified between planned and delivered care. Residents and their representatives to whom the inspector spoke were complementary of the care, compassion and consideration afforded to them by staff in the centre.

The inspector observed staff in the delivery of care to residents, interacted with staff and reviewed records including medical records, nursing records, correspondence from other healthcare facilities. The centre had a care planning system in place and most resident's assessed needs were set out in residents' care plans. Most but not all assessments and care plans were reviewed four-monthly or more frequently as required. Most but not all residents had a daily nursing record of each resident's health, condition and treatment given and these records seen were adequate and informative. Each resident's vital signs were recorded regularly with action taken in response to any variations. This included nursing assessments, care plans and clinical risk assessments. Based on a random sample of care plans reviewed; the inspector was satisfied that overall the care plans generally reflected the resident's assessed needs. However, there were a number of improvements required in relation to the care planning including:
● some of the care plans did not have adequate details of the nursing care to guide practice for example not all care plans reviewed had an end of life or oral or dental care plans
● there was an inadequate assessment of residents' social care needs including meaningful activities
● the reviews of care plans were not conducted every four months as required by regulation
● not all risk assessments had been suitably reviewed including the risks of missing persons, smoking and manual handling.

In addition, there were three residents who had been recently admitted to the centre for respite care however, there were no care plans available for these residents. On the second day of inspection the person in charge confirmed that these three respite residents now had care plans in place.

Judgment:
Non Compliant - Major

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

Findings:
Policies and procedures which compiled with legislative requirements were in place for the management of complaints and this included an appeals process. Staff spoken with were familiar with the procedure for receiving and recording complaints. Residents were aware of the process which was displayed at the main entrance to the centre. On review of the record of complaints there was evidence that complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcome of their complaint however, reviews to ascertain the level of satisfaction of the complainant, further to issues being resolved/or not, were not carried out for all complaints.

Judgment:
Substantially Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Residents and relatives spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to the residents. The inspector observed positive interactions between staff and residents over the course of the inspection and found staff to have good knowledge of residents' needs as well as their likes and dislikes. The staffing rota confirmed that there was a nurse on duty at all times. Staff spoken to informed the inspector that there was a full complement of staff as per the staff duty roster and overall the inspector was satisfied that at all times, there were adequate staff with the right skills, qualifications and experience to meet the assessed needs of the residents. A number of staff spoken to had worked in the centre for long periods and some since the centre opened in 2000 and clearly demonstrated a good understanding of their role and responsibilities in relation to ensuring appropriate delivery of person-centred care to residents.

From speaking to the person in charge and a review of documentation; staff appeared to be supervised appropriate to their role and responsibilities. The person in charge

discussed staff issues with the inspector and suitable protocols and records were seen to be in place where concerns had been identified. There was an education and training programme available to staff. The training matrix indicated that most mandatory training was provided and a number of staff had attended training in areas such as cardio pulmonary resuscitation (CPR) and elder abuse. However, not all staff had completed mandatory training in fire evacuation or fire training, the detection and prevention of and responses to abuse and responding to and manage behaviours that were challenging. These failings were discussed and actioned under outcome 7 and 8 of this report. In addition, the on-going education and training programme was not adequate as not all staff had up to date training in for example medication management and infection prevention and control.

The inspector reviewed a sample of staff files which included the information required under Schedule 2 of the regulations. Registration details with Bord Altranais agus Cnáimhseachais na hÉireann, or Nursing and Midwifery Board of Ireland for 2017 for nursing staff were seen by the inspector.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Vincent Kearns
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

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

Provider's response to inspection report[1]

Centre name:	St. Teresa's Nursing Home
Centre ID:	OSV-0000293
Date of inspection:	05/04/2017
Date of response:	20/05/2017

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 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

1. Action Required:

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

Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

Please state the actions you have taken or are planning to take:
We have recently changed to using the NHI contracts for care. We will add the schedule of fees and an appendix relating to the accommodation being a single or double room.

Proposed Timescale: 12/06/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

2. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
We will agree in writing with each resident, on the admission to the nursing home, the terms in which that resident shall reside in the nursing home. We will ensure all residents have a contract of care agreed in writing on admission to the centre

Proposed Timescale: 12/06/2017

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:
To review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

3. Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
We will review and update all our policies in accordance with best practice.

Proposed Timescale: 12/06/2017

Outcome 06: Absence of the Person in charge

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

4. Action Required:
Under Regulation 32(1) you are required to: Provide notice in writing to the Chief Inspector where the person in charge proposes to be absent from the designated centre for a continuous period of 28 days or more.

Please state the actions you have taken or are planning to take:
In future we will send the notification to HIQA in a timely manner to inform you of any absenteeism over 28 days and/or changes to our PIC.

Proposed Timescale: 08/05/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To give notice in writing to the Chief Inspector of the arrangements that have been, or are proposed to be, made for appointing another person in charge to manage the designated centre during that absence of the person in charge, including the proposed date by which the appointment is to be made.

5. Action Required:
Under Regulation 33(2)(b) you are required to: Give notice in writing to the Chief Inspector of the arrangements that have been, or are proposed to be, made for appointing another person in charge to manage the designated centre during that absence of the person in charge, including the proposed date by which the appointment is to be made.

Please state the actions you have taken or are planning to take:
We will inform HIQA in the future of each and every arrangement we make to try and recruit a new PIC should the situation arise again.

Proposed Timescale: 08/05/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To gve notice in writing to the Chief Inspector of the arrangements which have been or were made for the running of the designated centre during the absence of the person in charge.

6. Action Required:
Under Regulation 33(2)(a) you are required to: Give notice in writing to the Chief Inspector of the arrangements which have been or were made for the running of the designated centre during the absence of the person in charge.

Please state the actions you have taken or are planning to take:
We will ensure to give notice in writing to the Chief Inspector of the arrangements for the running of the designated centre during the absence of the person in charge should this issue arise again.

Proposed Timescale: 08/05/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To give notice in writing to the Chief Inspector of the name, contact details and qualifications of the person who will be or was responsible for the designated centre during the absence of the person in charge

7. Action Required:
Under Regulation 33(2)(c) you are required to: Give notice in writing to the Chief Inspector of the name, contact details and qualifications of the person who will be or was responsible for the designated centre during the absence of the person in charge.

Please state the actions you have taken or are planning to take:
We will inform HIQA of the name, contact details and qualifications of the person who will be or is responsible for the designated centre during the absence of the person in charge.

Proposed Timescale: 08/05/2017

Theme:

Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 33(2).

8. Action Required:
Under Regulation 33(1) you are required to: Give notice in writing to the Chief Inspector of the procedures and arrangements that will be in place for the management of the designated centre during the absence of the person in charge, setting out the matters contained in Regulation 33(2).

Please state the actions you have taken or are planning to take:
We will give notice in writing of the procedure and arrangements that will be in place should our PIC be absent in the future.

Proposed Timescale: 08/05/2017

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:
To ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

9. 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:
15 staff members have attended responsive behaviour training. We will ensure all staff members have up to date knowledge to respond to and manage behaviour that is challenging.

Proposed Timescale: 10/07/2017

Theme:
Safe care and support

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

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 and ensure that issues such as consent, care planning and using the least restrictive or alternative method of restraint.

10. 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:
As per national policy we will continue to use bed rails as the only restraint in our home. We will ensure all the appropriate paperwork i.e. our restraint policy and the comprehensive assessment mentioned in the report, will be updated and filled out for every resident who is deemed to require bed rails for their safety. We will always endeavour to use the least restrictive method of restraint and continue using our crash mats and low profiling beds to eliminate the use of bed rails when possible, to keep in line with Regulation 07(3) and the guidelines printed on the website of the department of health from time to time.

Proposed Timescale: 10/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure staff are trained in the detection and prevention of and responses to abuse.

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

Please state the actions you have taken or are planning to take:
All staff has been trained in the prevention and detection of abuse. We will update the training annually as per national policy.

Proposed Timescale: 10/07/2017

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:
Ensure that the risk management policy set out in Schedule 5 includes hazard

identification and assessment of risks throughout the designated centre including risk assessments in relation to residents' capacity to smoke tobacco safely and accident reports were not comprehensively completed.

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

Please state the actions you have taken or are planning to take:
We will ensure the risk management policy includes hazard identification and risk assessments for throughout the nursing home.

Proposed Timescale: 10/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

13. Action Required:
Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
A risk assessment measuring the actions and controls in place for aggression and violence will be carried out and the relevant documentation completed.

Proposed Timescale: 10/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre including: the stair bannisters, unrestricted access to two sluice rooms, the design and layout of the sluice rooms, the storage of latex gloves and plastic aprons and access of any resident with a cognitive impairment to the lift.

14. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy

set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
We will ensure the risk management policy includes the risks posed by the stair banisters, two sluice rooms, storage of gloves and access to the lift for residents with a cognitive impairment. The risks will be assessed, rated and controls put in place if necessary.

Proposed Timescale: 10/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

15. Action Required:
Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

Please state the actions you have taken or are planning to take:
A risk assessment measuring the actions and controls in place for the unexplained absence of a resident will be carried out and the relevant documentation completed.

Proposed Timescale: 10/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

16. Action Required:
Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
A risk assessment measuring the actions and controls in place for accidental injury to residents, visitors and staff will be carried out and documentation completed

Proposed Timescale: 10/07/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

17. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
All staff completed the HSE land module for hand hygiene which includes the control of infection in the workplace

Proposed Timescale: 10/04/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

Please state the actions you have taken or are planning to take:
All staff received fire training on May 8th .This included evacuation procedures, building layout and escape routes, location of fire alarm call points, firefighting equipment, and fire control techniques. Training was also carried out in January and October 2016.

Proposed Timescale: 08/05/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To make adequate arrangements for detecting, containing and extinguishing fires including ensuring that fire safety doors are not wedged open

19. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
We will ensure fire safety doors are not held open in the future.

Proposed Timescale: 06/04/2017

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:
To store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Please state the actions you have taken or are planning to take:
The laxose and Movicol are now being stored in the medications trolley.

Proposed Timescale: 08/05/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
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 including ensuring all medications are administered, stored or transcribed in accordance with legal requirements.

21. 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:
We have requested the GPs to document on each prescription chart RE the crushing of medications. We have requested that any medications which can be given in a liquid format for certain residents be prescribed as such to avoid crushing

Proposed Timescale: 10/07/2017

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:
To arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre including respite admissions.

22. Action Required:
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
We carry out pre admission assessments in the hospital prior to a resident coming for long term care. We also ensure a comprehensive admission is completed once they arrive at the home. We will include our activities co-ordinator in this assessment to ensure the personal and social care needs of our residents are catered to. We receive a detailed handover from the hospital staff and the discharge coordinator to ensure we can cater to the needs of residents coming to us for respite and we develop a care plan to suit their needs on arrival to the home.

Proposed Timescale: 10/07/2017

Theme:
Effective care and support

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

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 including residents admitted for respite care.

23. 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:
Care plans for respite residents were initiated the day of the inspection and the inspector was informed. We will prepare a care plan for all residents within 48hrs of admission.

Proposed Timescale: 06/04/2017

Theme:
Effective care and support

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

24. 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:
The care plans will be reviewed and updated at intervals not exceeding 4 months.

Proposed Timescale:
10/07/2017 ongoing

Proposed Timescale: 10/07/2017

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:
To ensure that the nominated person maintains a record of all complaints including

details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

25. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
We will ensure our complaints process is robust and includes every step of the complaints procedure. The outcome of the complaint and whether or not the resident was satisfied will also be documented.

Proposed Timescale: 10/07/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that staff have access to appropriate training including medication management and infection prevention and control.

26. 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:
The provider nominee will ensure all staff will have access to and have completed medication management and infection prevention and control.

Proposed Timescale: 10/07/2017