<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Kieran's Care Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000432</td>
</tr>
<tr>
<td>Centre address:</td>
<td>The Pike, Rathcabban, Roscrea, Tipperary.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>057 913 9069</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:stkieransnh@gmail.com">stkieransnh@gmail.com</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>St. Kieran’s Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Eimear Gormally</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary Costelloe</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>22</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
</tr>
</tbody>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>27 February 2017 10:00</td>
<td>27 February 2017 17:30</td>
</tr>
<tr>
<td>28 February 2017 10:00</td>
<td>28 February 2017 16:30</td>
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</tbody>
</table>

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

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

This report sets out the findings of an inspection, which took place following an application to the Health Information and Quality Authority, to renew registration. This inspection was announced and took place over two days. As part of the inspection the inspector met with residents, relatives and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.
Overall, the inspector found that the governance arrangements in place did not ensure that the service provided was safe, consistent and effectively monitored. The current provider representative who had been recently appointed lived abroad but was contactable by telephone and email. There was inadequate oversight of all areas such as documentation, risk management, fire safety, staff induction, staff training and safeguarding to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. There was no annual review of the quality and safety of care delivered to residents. There were inadequate systems in place to ensure transparency in the management of residents’ fees.

The communal day areas were bright, homely and comfortably furnished. While some recent renovations had taken place to the premises, further improvements were required in order to meet the needs of residents and reflect the aims set out in the statement of purpose. There was no secure accessible external space provided for residents.

On the days of inspection, the inspector was satisfied that the residents were cared for in a safe environment and that their nursing and healthcare needs were being met. The inspector observed sufficient staffing and skill-mix on duty during the inspection and staff rotas confirmed these staffing levels to be the norm.

The quality of residents’ lives was enhanced by the provision of a choice of interesting things for them to do during the day and an ethos of respect and dignity for both residents and staff was evident.

Residents, relatives and staff all commented on the homely, relaxed atmosphere in the centre. Staff demonstrated a comprehensive knowledge of residents’ needs, their likes, dislikes and preferences. Staff and residents knew each other well, referring to each other by first names. Residents were observed to be relaxed and comfortable when conversing with staff.

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

Improvements were required to the overall governance arrangements, formally reviewing the quality and safety of care, updating and implementation of policies, updating the risk register, staff induction and training, improvements were required to ensuring transparency in the management of residents fees and monies kept for safekeeping.

These areas for improvement are set out in the action plan at the end of the report.
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 inspector reviewed the statement of purpose dated December 2016 which was submitted in advance with the application to renew registration.

The statement of purpose did not comply with the requirements of schedule 1 of the regulations. It did not include all of the information set out in the certificate of registration, the age range and sex of the residents for whom accommodation is provided, the arrangements for the management of the centre in the absence of the person in charge, the arrangement's made for consultation with, and participation of residents in the operation of the centre, arrangements made for contact between residents and their relatives, friends and or carers, the fire precautions and associated emergency procedures in the centre. The organisation structure was not up to date and the arrangements for the privacy and dignity of residents referred to and named another centre.

Judgment:
Non Compliant - Moderate

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):
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
The inspector had concerns regarding the overall governance and management of the centre. The current provider representative was unavailable and unable to attend the inspection.

The person in charge had been appointed to the post in April 2016. She worked full time and had the appropriate experience and qualifications for the role. She was on call out of hours 24 hours a day, seven days a week. The inspector noted a notice displayed indicating that the person in charge was on call 24/7. However, the governance arrangements did not fully support the person in charge to ensure that the service provided was safe, consistent and effectively monitored. There were no formal deputising arrangements in place in the absence of the person in charge and there is no administrative support provided to the person in charge.

The current provider was appointed in November 2016 on the death of her father, who previously fulfilled this role. The person in charge stated that she had met with the previous and current provider representatives on a few occasions but no formal management meetings had taken place. The person in charge advised that the current provider representative lived abroad but was contactable by telephone and email.

While the person in charge and nursing staff had completed some audits and reviews of areas such as medicines management, infection control, falls, health and safety and privacy and dignity, there was no annual review of the quality and safety of care delivered to residents.

There was inadequate oversight of all areas such as documentation, risk management, fire safety management, staff induction, staff training, safeguarding, updating and implementation of policies to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. Systems for the management and recording of residents’ fees and monies paid to the provider were not transparent.

These issues are discussed further throughout the report and included in the action plan at the end of the report.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.
**Findings:**
The inspector was shown a copy of the resident's guide. The guide required updating to include the terms and conditions relating to residence in the centre, the procedure concerning complaints and the arrangements for visits. The residents guide was not displayed and not available to residents.

The person in charge advised the inspector that contracts of care were in place for all residents. The inspector reviewed a sample of contracts of care. While they included details of the services to be provided, fees to be charged and details of additional charges, the agreement did not set out details of and, where appropriate the arrangements for the application for or receipt of financial support under the Nursing Support Scheme including the arrangements for the payment of or refund of monies. The person in charge stated that she did not know what arrangements were in place for invoicing of residents as she had no involvement with management of finances.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
The person in charge was a nurse and worked full-time in the centre. She had the required experience in the area of nursing the older adult. The person in charge was knowledgeable regarding the regulations, HIQA's Standards and her statutory responsibilities. She was very knowledgeable regarding the individual needs of each resident.

The person in charge had engaged in continuous professional development. She had recently attended 'Train the trainer' safeguarding and manual handling instructor training courses. She had attended dementia awareness and falls prevention days.

The inspector observed that she was well known to staff, residents and relatives.

**Judgment:**
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector was satisfied that records as required by the Regulations were generally maintained in the centre however, improvements were required to updating and implementing policies, the register of residents, staff files and accurately recording staff training records.

All policies as required by Schedule 5 of the regulations were available and had been reviewed during 2016. However, some polices required updating to reflect best practice and national guidelines. See Outcome 7: Safeguarding in relation to policies on prevention, detection and response to abuse, Outcome 13: Complaints and Outcome 18: Staffing.

Some practices in the centre were not reflective of the centres policies. See Outcome 7: Safeguarding and Outcome18: Staffing.

The date of commencement of employment was not always included in staff files reviewed.

The staff training matrix presented to the inspector was found to be inaccurate in that fire safety training had not been completed by all staff during 2016 as indicated.

The inspector reviewed the directory of residents and noted that it required updating to fully comply with the requirements of the regulations.

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:
The person in charge was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge. Notifications as required had been submitted in the past.

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

Findings:
The inspector noted that while some systems were in place to protect residents from harm and abuse, improvements were required to ensuring transparency in the management of residents’ fees and monies kept for safekeeping, training for staff and updating of policies. Some of these issues had been brought to the attention of the provider in the previous inspection report.

The inspector reviewed the policy on elder abuse which had been reviewed in May 2016. The policy required updating to reflect up-to-date guidelines on safeguarding. Training records reviewed and staff spoken with indicated that some staff had not received recent training on the detection, response to and management of abuse. Recently recruited members of staff had not received training and some staff members spoken with were not knowledgeable or confident of recognising the signs of abuse. The person in charge told the inspector that she had recently completed a ‘train the trainer’ safeguarding course and was planning to train all staff in house and update the policy guiding practice. On day two of the inspection she confirmed that she had scheduled safeguarding training with all staff on the 6 and 7 March 2017 and had reorganised that staff roster to facilitate this. Some staff spoken with very aware of their responsibilities in this area and said that there were no barriers to the reporting of any alleged or
suspected abuse and they had every confidence that the person in charge would take appropriate safeguarding measures if necessary. The person in charge said that there had been no allegations of abuse reported. Residents spoken with and those that responded to questionnaires in advance of the inspection by way of feedback to HIQA stated that they felt safe in the centre. Safeguarding information including the name of the designated officer was displayed at the entrance to the day room.

Systems for the management and recording of residents’ fees and monies paid to the provider were not transparent. There were no records available in the centre. The person in charge stated that she did not know what arrangements were in place for invoicing of residents as she had no involvement with management of finances.

Small amounts of money were kept for safekeeping on behalf of a number of residents. Individual records were maintained which included all lodgements and withdrawals. Most transactions included the signature of two staff however, this was not the case in one account reviewed. Receipts were not available for all amounts withdrawn including items such as hairdressing. The inspector checked the balance of a sample of accounts and they were found to be correct. The person in charge carried out monthly balance checks on all accounts, these checks were recorded.

The inspector reviewed the polices on use of restraint and behaviour that challenges, both of which had been reviewed in May 2016. The policy on restraint included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible.

Staff continued to promote a restraint free environment. There were seven residents using bedrails at the time of inspection. The inspector noted that risk assessments for the use of bedrails, alternatives tried or considered and care plans were documented in all cases. Staff carried out regular checks on residents using bedrails and these checks were recorded.

Staff informed the inspector that there few residents with a dementia and currently no residents who presented with responsive behaviour. Some residents with anxiety had care plans in place which outlined guidance for staff as to how to reassure residents. The inspector noted that PRN (as required) medicines were prescribed for a small number of residents but seldom administered.

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

**Findings:**
While there were some systems in place to protect the health and safety of residents, staff and visitors, improvements were required to fire safety, risk management and infection control. Some of these issues had been previously brought to the attention of the provider.

There was a health and safety statement available. There was a risk register which included the risks mentioned in the regulations but all risks in the centre had not been identified and included. The inspector noted that measures identified to control specific risks were not in place. For example, 'an enclosed back garden for residents to wander safely in' was included as a control measure in place to reduce the risk of resident absconion and 'medication trolley stored in the treatment room when not in use which has a key coded entry system' was included as a control measure to reduce the risk of medication error. The control measures mentioned were not in place.

The inspector noted that risks associated with the use of hoists, clinical waste, needle stick injury, cleaning chemicals, defective garden furniture had not been identified and assessed. The inspector noted that cleaning chemicals in use were stored in unlabelled spray bottles which posed a risk to residents, staff and visitors.

There was an emergency plan in place which included guidance for staff as to what their role might be in the event of a range of emergencies including power failure, fire and evacuation. A personal emergency evacuation plan had been documented for each resident and was included inside each wardrobe door however, some of the plans had not been reviewed since May 2016.

Training records reviewed indicated that all staff members had not received up-to-date training in moving and handling and some recently recruited staff had no training. The person in charge advised the inspector on day two of the inspection that training had been scheduled for all staff on the 10 March 2017. The training notice was displayed on the notice board. Staff informed the inspector that three residents required the use of hoists. Each resident had been assessed by the physiotherapist and occupational therapist for individual slings which were in use. A new specialised sling had been ordered for one resident following a recent assessment. The inspector observed good practice in relation to moving and handling of residents during the inspection. The service records for the two hoists in use were up to date.

The person in charge had put a system in place for recording of incidents. The inspector reviewed the incident log and noted that details of incidents were recorded. The last recorded incident had taken place in November 2016. Records and falls audits reviewed indicated that there was a low incidence of falls in the centre.

The inspector reviewed the fire policies and procedures. Records indicated that all fire fighting equipment had been serviced in January 2017 and the fire alarm was serviced on a quarterly basis. The fire alarm was last serviced in January 2017. Daily and weekly fire safety checks were carried out and these checks were recorded. The last fire drill took place in May 2016 and included outcomes and follow up actions. The person in
charge informed the inspector that there had been no recent fire drill.

Fire safety training had taken place twice in 2016 however, the inspector noted that many staff had not received training in 2016 and new staff members had not received any training. This was brought to the attention of the person in charge on the morning of the first day of the inspection. She immediately arranged fire safety training for the afternoon of that same day. She confirmed that all staff with the exception of two had up to date training.

Handrails were provided to all circulation areas and grab rails were provided in all toilets and bathrooms. Call-bell facilities were provided in all rooms.

The inspector noted some improvements were required in relation to some aspects of infection control. There was an infection control policy in place. Hand sanitising dispensing units were located at the front entrance and throughout the building. Staff were observed to be vigilant in their use. The building was found to be visibly clean and odour free. Regular infection control audits had been carried out by nursing staff and issues recently identified such as pedal bins had been provided.

The inspector spoke with housekeeping staff regarding cleaning procedures. Staff were knowledgeable regarding infection prevention and control procedures including colour coding and use of appropriate cleaning chemicals. However, the inspector noted that while colour coded cloths were in use, the same cloth was being used to clean a number of rooms contrary to best practice. The cleaning staff on duty told the inspector that there were insufficient cloths available. Cleaning equipment including clean cloths and mop heads were being stored in the sluice room adjacent to a bed pan washer which posed an infection control risk. Some staff including housekeeping staff spoken with had not received infection control training. On the second day of inspection the person in charge informed the inspector that she had scheduled infection control training for staff on the 6 and 7 March 2017.

**Judgment:**
Non Compliant - Major

**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 generally found evidence of good medicines management practices and sufficient policies and procedures to support and guide practice. However, nursing staff had not received recent medicines management training and systems for returning
medicines to the pharmacy required improvement.

The inspector spoke with a nurse on duty regarding medicines management issues. The nurse demonstrated her competence and knowledge when outlining procedures and practices on medicines management.

Medicines requiring strict controls were appropriately stored and managed. Secure refrigerated storage was provided for medicines that required specific temperature control. The temperature of the refrigerator was monitored and recorded on a daily basis.

The inspector reviewed a sample of medicines prescribing/administration sheets. All medicines were regularly reviewed by the general practitioners (GP).

Systems were in place to record medicine errors and staff were familiar with them.

Systems were in place for checking medicines on receipt from the pharmacy.

Records were maintained of all unused/out-of-date medicines returned to the pharmacy however, these had not been signed.

Regular medicines management audits were carried out by the nursing staff and the pharmacy. Recent audits reviewed had not identified any improvements required.

Nursing staff spoken with and training records reviewed indicated that nurses had not attended recent medicines management training. This is included in an action under Outcome 18: Staffing.

Judgment:
Substantially Compliant

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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:
The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. To date all relevant incidents had been notified to the Chief Inspector by the person in charge.

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):
No actions were required from the previous inspection.

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

All residents had access to a choice of general practitioner (GP) services. There was an out-of-hours GP service available. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis and medical records supported that GP review was timely and responsive.

A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services and psychiatry of later life. Chiropody and optical services were also provided. The inspector reviewed residents’ records and found that residents had been referred to these services and results of appointments and recommendations were written up in the residents’ notes. The physiotherapist visited weekly and assessed all residents post falls as well as carrying out group and one to one exercise programmes. The OT visited regularly and completed seating assessments as required and assessed residents manual handling requirements.

The inspector reviewed a number of residents’ files including the files of residents with restraint measures in place, nutritionally at risk, with wounds and presenting with anxiety. See Outcome 7 Safeguarding and Safety regarding restraint and behaviours that challenge.

A range of risk assessments had been completed including nutrition, dependency, manual handling, falls, bedrail use and skin integrity. Some care plans were detailed, guided the care of the residents and were person centered. Systems were in place to record evidence of residents/relatives involvement in the development and review of their care plans.

However, the inspector noted some inconsistencies in the nursing documentation and while staff spoken with were very knowledgeable regarding individual residents needs
this information was not always reflected in the nursing documentation. While there was evidence of regular review of care plans, the inspector noted that some residents had been recently reviewed by the SALT and OT, however, the recommendations had not been updated in residents care plans. The recently changed needs of another resident had not been clearly updated in his care plans.

The inspector was satisfied that weight loss was closely monitored; residents were nutritionally assessed using a validated assessment tool. All residents were weighed monthly or more often if staff had concerns. Nursing staff told the inspector that if there was a change in a resident’s weight, nursing staff would reassess the resident, liaise with the GP and referrals maybe made to the dietician and or SALT. Files reviewed by the inspector confirmed this to be the case. Some residents were prescribed nutritional supplements which were administered as prescribed.

There were a small number of residents with wounds, there were no residents with pressure ulcers at the time of inspection. The inspector was satisfied that wounds were being well managed. There were adequate up-to-date wound assessments and wound charts in place. There was evidence of referral and assessment by the vascular consultant.

Residents' social care needs were met through a varied and meaningful activity programme. There was an activities co-ordinator on duty seven days a week from 8.00 to 18.00 hours. The activities schedule was displayed in the day room. Both group and 1:1 activities took place. Regular activities offered included reading the newspapers, hand massage, light exercise to music, sing a long, yoga, card games, reflexology, flower arranging, board games, movie afternoons and live music weekly. Residents were observed enjoying a variety of activities during the inspection and residents spoken with told the inspector that they enjoyed then variety of activities taking place. The activities coordinator had recently completed SONAS training (a therapeutic programme for residents with Alzheimer's disease).

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

Findings:
Issues identified at the last inspection had been addressed and some recent renovations had taken place, however, the inspector noted that further improvements were required in order to meet the needs of residents and reflect the aims set out in the statement of purpose.

Accommodation for residents was provided on the ground floor, staff facilities were provided on the first floor.

The building accommodated 23 residents in eight twin and seven single bedrooms. Some of the twin bedrooms because of their size and layout were unsuitable for use by residents who required the use of specialised equipment such as hoists or chairs. The person in charge confirmed that residents needs were assessed prior to admission to ensure that a suitable bedroom was available to meet their needs. Screening curtains were provided in all shared bedrooms and wardrobes with sliding doors had been fitted to maximise space. Many of the bedrooms were personalised with residents own photographs and personal items.

There a glass door to one bedroom. While the door had been fitted with opaque glass and a net curtain, the inspector noted that the privacy and dignity of the resident using this bedroom was compromised.

There were two assisted showers and four toilets for the use of residents. There was no bath provided therefore residents did not have a choice of bath or shower. There were three doors leading into some of the toilets which potentially posed a risk to the privacy and dignity of residents.

The communal day areas including the entrance area, day room, dining room and 'primrose cottage' which was used as a visitors space were bright and comfortable. They were appropriately furnished in a homely manner. Residents spoken with stated that they liked the communal day areas and their bedrooms.

There was a well equipped, kitchen, laundry and sluice room. There was no separate cleaners’ room; this posed an infection control risk.

Staff facilities including a kitchenette, changing room and toilets were provided on the first floor.

There was no secure accessible external space provided for residents. There was a paved external patio area accessible from the main day room, however, this area was not secure, the garden benches were defective and the metal support provided to the hand rail at the ramp leading to the area was rusted and defective.

**Judgment:**
Non Compliant - Moderate

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

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

**Findings:**
The complaints policy which was in the process of review was shown to the inspector. It contained details of the designated complaints officer, the designated officer to oversee complaints and details of the appeals process. The policy had not yet been signed and implemented. This action is included under Outcome 5: Documentation.

On day one of the inspection the complaints policy displayed required updating to reflect the complaints procedure outlined in the statement of purpose. The person in charge undertook to update the procedure and had it displayed in a prominent position on day two of the inspection.

The inspector reviewed the complaints log, there were no complaints documented. The person in charge advised the inspector that no complaints had been received. Verbal concerns raised by residents were recorded in the concerns log and related to issues including missing items such as clothing, glasses, a brooch and over bed light not working. All of these issues had been addressed by staff to the satisfaction of residents.

**Judgment:**
Substantially Compliant

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**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:**
The inspector was satisfied that caring for a resident at end of life was regarded as an integral part of the care service provided in centre.

There was an end-of-life policy in place. Staff confirmed that support and advice was available from the community home care team and local hospice care team. There were no residents at end of life at the time of inspection.
Residents’ needs and wishes were discussed with residents and their representatives. The inspector noted that the individual wishes of residents were clearly outlined in their files.

Residents were accommodated in both single and shared rooms. The person in charge and staff spoken with stated that a single room was facilitated for those in shared rooms during end-of-life care if available. Families were facilitated to stay overnight if they wished. Families were provided with snacks, meals and refreshments during their visits.

Some staff had attended end of life training.

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 nutrition policy in place. Residents were offered a varied nutritious diet. The quality and presentation of the meals were of a high standard and a number of the residents told inspectors that the food was always very good. Some residents required special diets or modified consistency diets and these needs were met.

The inspector spoke with the chef who was knowledgeable regarding residents special diets, likes and dislikes. There was a three week rolling menu in place which offered choice at every meal. The chef told the inspector that the dietician reviewed the menus which were changed on a three monthly basis. She stated that she spoke with residents regularly to obtain their views on the menu.

The menus were clearly displayed both on the individual tables and on a large black board in the dining room.

Residents stated that food, drinks and snacks were available to them at all times. A variety of hot and cold drinks and snacks were available throughout the day. Staff were observed offering and encouraging drinks throughout the days of inspection. The inspector saw a variety of home-cooked food being served throughout the days of inspection including scones, brown bread, buns and soups.
Residents spoken with confirmed that they were offered a choice at every meal and some told the inspector that one could always get something they liked even if it was not on the menu. Some residents told the inspector that they loved fish and could have it every day if they wished.

The inspector observed the dining experience and noted it to be a pleasant one. Meals were served in a large bright dining room. The table settings were attractive with table cloths, condiment sets, sauces, butter and serviettes provided. A choice of drinks was offered. The atmosphere during lunch was relaxed and unhurried. It was seen as an opportunity for social interaction with good banter and plenty of chat between residents and staff. Staff were observed to sit beside residents who required assistance with their meals while encouraging other residents to eat independently.

**Judgment:**
Compliant

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**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:**
Staff were observed to treat residents in a dignified manner and in a way that maximised their choice and independence. The inspector observed that residents were always referred to by their first name and politely asked if they needed anything, given choices around what they would like to do, where they would like to sit and what they would like to eat and drink. The inspector noted that the privacy and dignity of residents was well respected. Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Residents spoken to confirmed that their privacy was respected.

Staff paid particular attention to residents’ appearance and personal hygiene and were observed to be caring towards the residents. Many residents spoken with praised the staff stating that they were kind, caring and treated them with respect.

A number of the questionnaires completed by residents and family members by way of feedback to HIQA confirmed that the centre made every effort to maintain residents’
independence. Staff and residents confirmed that there are no set times or routines in terms of when a resident must get up in the morning or go to bed at night. Residents had a choice of having their meals in the dining room, at a chair in the day room or in their bedroom.

Residents’ religious and political rights were facilitated. Mass was celebrated monthly in the centre. A minister of the Eucharist visited the centre on a weekly basis and offered holy communion to residents. Arrangements were in place for residents of different religious beliefs. Staff told the inspector that residents were facilitated to vote and explained that residents had been facilitated to vote in-house during recent elections.

There was an open visiting policy in place. The inspector observed visitors coming and going throughout the inspection. Relatives spoken with and those that completed questionnaires indicated that they were always made to feel welcome by staff. Residents had access to the centre's cordless phones and some residents had their own mobile handset device.

The centre was part of the local community and residents had access to radio, television, the internet, magazines, daily and regional newspapers were provided. Some residents told the inspector how they enjoyed reading the daily newspapers and Irelands Own magazine. The activities coordinator stated that she regularly read and discussed news topics from the newspapers. She outlined how many of the residents enjoyed this particularly the head line news items and sport reviews. The inspector observed this taking place in practice. One resident used his own laptop computer.

Residents had recently been involved the production of a DVD in which residents had been interviewed and spoke of their interesting and varied life histories. This was followed by a DVD launch night when residents enjoyed watched themselves and had light refreshments.

Photographs were displayed of residents enjoying a variety of events including a recent visit by members of the Tipperary hurling team with the Liam McCarthy cup and visits by the dog therapist.

Staff outlined to the inspector how links were maintained with the local community. Most of the residents and staff were from the local rural area. Many of the residents had known each other and many were related to one another. Some residents went out on day trips with their families regularly while others attended special family occasions. Local musicians and school children visited, the local library visited, the local priest visited monthly and the minister of the Eucharist visited weekly. Many of the staff were from the local area and chatted with residents about local news and sporting topics. Day trips were arranged during the summer months and residents spoke about having enjoyed trips to places of local interest.

**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.

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Person-centred care and support</th>
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**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There was a laundry room with ample space for washing/drying and sorting of residents’ clothing. The inspector noted that good care was taken of residents’ personal laundry. Residents were satisfied with the laundry arrangements and stated that mislaid clothing was not generally an issue. The inspector noted that all items of residents clothing were discreetly labelled.

Adequate personal storage space including a wardrobe and lockable locker was provided in residents’ bedrooms.

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<th>Judgment:</th>
<th>Compliant</th>
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**Outcome 18: Suitable Staffing**

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

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Workforce</th>
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**Outstanding requirement(s) from previous inspection(s):**

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

**Findings:**

During the inspection, staffing levels and skill mix were sufficient to meet the assessed needs of the 22 residents living in the centre, however, improvements were required to the staff recruitment, induction and training processes.

There was nurse and three care staff on duty throughout the morning, afternoon and evening time, one nurse and two care staff on duty up until 21.00hours and one nurse
and one care assistant on duty at night time. The person in charge was normally on
duty during the day time Monday to Friday and was on call out of hours and at
weekends. In addition there were normally two catering, two housekeeping and an
activities therapist on duty during the day time. Residents and staff spoken with were
satisfied that there were adequate staffing levels and skill mix. The duty roster reviewed
indicated that this was the normal staffing pattern.

The inspector noted that improvements were required to the recruitment and induction
process. There were recruitment, staff training and development policies in place. The
recruitment policy required updating to reflect Garda Síochána vetting requirements.

The inspector noted that the policy on staff training and development was not
implemented in practice. The policy outlined that staff should complete a 12 week
induction programme as part of their probationary employment and that the induction
training booklet would be signed by the person in charge when the staff member had
demonstrated a sound basic understanding of a variety of subject areas. This was not
happening in practice. This action is included under Outcome 5: Documentation.

The inspector spoke with recently recruited staff members and also reviewed staff files.
Staff confirmed that they had received one day's orientation but had not received
comprehensive induction or training. There were no records of induction training
completed maintained on staff files.

The inspector reviewed a sample of staff files. Staff files were found to contain most of
the documents as required by the Regulations, including Garda Síochána vetting,
photographic identification, references and nursing registration numbers. However, the
date of commencement of employment was not always available. This action is included
under Outcome 5: Documentation.

The person in charge told the inspector that Garda Síochána vetting was in place for all
staff and for all other persons who provided services to residents in the centre. She
stated that there were no volunteers attending the centre.

The inspector noted that training provided to staff was limited during 2016. As
previously discussed under Outcomes 7, 9 and 11 all staff did not have up to date
training in fire safety, manual handling, infection control, safeguarding and medicines
management. The person in charge advised the inspector that she had put a training
plan in place and scheduled training in March 2017 in dementia care, challenging
behaviour and restraint, safeguarding vulnerable adults, infection control and manual
handling and patient moving. Fire safety training took part on day one of the inspection.

**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:

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

Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Kieran's Care Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000432</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27/02/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>29/03/2017</td>
</tr>
</tbody>
</table>

Requirements

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

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not comply with the requirements of schedule 1 of the regulations.

1. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
The Statement of Purpose has been reviewed and updated to reflect the information requirements set out in schedule 1 of the Health Act 2007.  
A copy of the revised SOP has been attached for review. The current Provider and the PIC are responsible for ensuring that the SOP is kept up to date going forward.

**Proposed Timescale:** 29/03/2017

### 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:**
The governance arrangements did not fully support the person in charge to ensure that the service provided was safe, consistent and effectively monitored. There were no formal deputising arrangements in place in the absence of the person in charge and there is no administrative support provided to the person in charge.

There was inadequate oversight of areas including documentation, risk management, fire safety management, staff induction, staff training, safeguarding, updating and implementation of policies to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. These issues are discussed further throughout the report.

2. **Action Required:**
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The current Provider has sanctioned the position of Clinical Nurse Manager to be filled by current senior staff nurse employed by the centre. An NF31 has been completed a copy of which is attached. This application has also been emailed to the Authority for review, a hard copy will also be posted.

The current Provider has also sanctioned the position of an office assistant. The Provider is currently in the process of arranging advertisement for this position. This person will be responsible to ensure that all newly employed staff would have the appropriate and necessary paperwork prior to commencement of Employment such as Garda Vetting/reference checks and Introduction programme for orientation. They would also be responsible for current staff files to be up to date to include such things as the commencement date of employment etc. The office assistant could also monitor staff training and assist in the management of when mandatory training is due and organise same, this would allow for the PIC to concentrate on other areas of
Governance & Management such as Risk Management, Audit and Quality Assurance.

In the interim a HCA with a secretarial has been temporarily appointed in order to begin work on these areas. This person is currently part time but is going to take on full time hours to include two days per week (15hrs) in the office. This has been agreed as a temporary position until the new person is appointed. Commenced 20.03.17

The current provider would hope the new office assistant would be appointed within the next 8 to 10 weeks to ensure enough time is allowed for all paperwork to be returned such as Garda Vetting. 30.05.17

Weekly updates will be provided to the Provider by email each Thursday to update on key areas included in the overall Governance and Management of the centre. The areas that were identified will be closely monitored and actioned such as Risk Management, Staff Training, Staff Recruitment and Orientation, Fire Safety Management, Updating and implementation of policies, and Safeguarding.

The provider will contact the PIC the next day and action plans will be devised where necessary with a review date for completion. This will be followed by a monthly meeting at the centre to ensure that the service is safe, appropriate, consistent, and effectively monitored. Minutes will be held for all meetings and stored within the office.

This system is to commence immediately 20.03.17

Proposed Timescale: 31/05/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review of the quality and safety of care delivered to residents.

3. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
The current provider and the PIC are currently gathering information, have commenced and are working on the annual report for 2016 to ensure Quality and Assurance are at the forefront of moving forward with the centre.

Proposed Timescale: 31/05/2017
<table>
<thead>
<tr>
<th>Outcome 03: Information for residents</th>
</tr>
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<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The residents guide was not displayed and not available to residents.</td>
</tr>
<tr>
<td><strong>4. Action Required:</strong> Under Regulation 20(1) you are required to: Prepare and make available to residents a guide in respect of the designated centre.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> The current Provider along with the PIC have reviewed and updated the Residents Guide and have ensured that all residents have received an updated copy. A copy of this guide is attached. Also going forward it will be the responsibility of the Provider to ensure that this guide continues to be updated as necessary, It is the responsibility of the PIC to ensure that this guide is displayed and made available to all residents residing within the centre. It is also the responsibility of the PIC to ensure that all new admissions receive a guide preferably prior to, but if not, then, on admission to the centre.</td>
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<td><strong>Proposed Timescale:</strong> 29/03/2017</td>
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<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The residents guide required updating to include the terms and conditions relating to residence in the centre.</td>
</tr>
<tr>
<td><strong>5. Action Required:</strong> Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> The current provider and the PIC have reviewed and updated the terms and conditions relating to residence within the centre. The residents guide has been updated to reflect these terms and conditions. As stated a copy of the residents guide is attached.</td>
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<tr>
<td><strong>Proposed Timescale:</strong> 29/03/2017</td>
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6. **Action Required:**
Under Regulation 20(2)(c) you are required to: Prepare a guide in respect of the designated centre which includes the procedure respecting complaints.

**Please state the actions you have taken or are planning to take:**
There has been a new Complaints procedure devised and accepted by the current Provider. The Residents Guide and the SOP have been updated to include this new procedure.

The new complaints procedure has been displayed at the entrance to the centre, on the resident notice board and will be discussed at the planned resident meeting on the 13th April.

The Complaints Policy has also been reviewed and updated to reflect the changes made.

A copy of the Complaints procedure is attached.

**Proposed Timescale:** 29/03/2017

7. **Action Required:**
Under Regulation 24(2)(c) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of the arrangements for the application for or receipt of financial support under the Nursing Support Scheme including the arrangements for the payment of or refund of monies. The person in charge stated that she did not know what arrangements were in place for invoicing of residents as she had no involvement with management of finances.

**Please state the actions you have taken or are planning to take:**
All contracts have been reviewed and changed to reflect the changes made. All
contracts clearly state the terms & conditions of residing within the centre and now also includes clear instruction regarding Payment and invoicing of fees. The invoice will include the daily charge for bed and board. The amount that the resident is responsible for and the amount that the Fair Deal Scheme is contributing. Additional charges such as Prescription fees, chiropody and hair Dressing will also be clearly evident.

These contracts now have been updated to include the current Provider and are being distributed for residents to sign. A residents meeting has been organised in order to discuss these changes, add changes that they may identify and address any issues there may be. This meeting is to be held on 13.04.2017

Residents and relatives are aware that all contracts are to be signed and returned before the 30.04.17

Copy of Contract of Care and Invoice attached

Proposed Timescale: 01/05/2017

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:
Some polices were not implemented and did not reflect practice in the centre See Outcome 7: Safeguarding in relation to policies on prevention, detection and response to abuse, Outcome 13: Complaints and Outcome 18: Staffing.

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

Please state the actions you have taken or are planning to take:
The policies mentioned above that is, prevention, detection and response to abuse, Complaints and Outcome and Staffing have been reviewed by the current provider and the PIC and have been updated to reflect the care within the centre.

Proposed Timescale: 29/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some policies required updating to reflect best practice and national guidelines. See Outcome 7: Safeguarding in relation to policies on prevention, detection and response to abuse, Outcome 13: Complaints and Outcome 18: Staffing.

9. **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:**
All policies will be reviewed by the current Provider and the PIC at least annually. Due for review June 2017

Those policies where best practice indicates will be updated and implemented immediately.

All changes to policies will be implemented in the care provided. Staff will become aware of these changes at regular toolbox talks at handovers and also by means of staff meetings.

**Proposed Timescale: 29/03/2017**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector reviewed the directory of residents and noted that it required updating to fully comply with the requirements of the regulations.

10. **Action Required:**
Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.

**Please state the actions you have taken or are planning to take:**
The Directory has been reviewed and updated
It is the responsibility of the PIC going forward to ensure that this remains up to date. Going forward the office administrator will also be part of ensuring that details are entered correctly as they arise.

**Proposed Timescale: 29/03/2017**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
The date of commencement of employment was not always included in staff files reviewed.

The staff training matrix presented to the inspector was found to be inaccurate in that fire safety training had not been completed by all staff during 2016 as indicated.

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

Please state the actions you have taken or are planning to take:
All staff files will be reviewed and updated to include the date of commencement of employment by the new office assistant. This has commenced 20.04.16

Staff training for all staff has since been completed on the 7th & 8th of March. This training included Dementia, Behaviours that Challenge, Safeguarding Vulnerable adults and Infection Control.

Manual Handling took place on the 10th March.

Fire Training was completed on the 1st day of inspection.

It is the responsibility of the PIC to ensure that Training will continue to be updated and monitored accordingly and within Best Practice.

The new training matrix will correctly reflect training completed and training due for renewal. This will be regularly monitored.

This will be facilitated with the help of the new office assistant.

Proposed Timescale: 29/03/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff had not received recent training on elder abuse, some staff had received training in relation to the detection and prevention and responses to abuse.

12. 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 mandatory training that is Fire, Manual Handling, Dementia Care, Elder Abuse, Behaviours that Challenging and Infection Control have now been completed and is up to date for 2016 for all existing employees

A new Orientation is being devised by the current provider and PIC and will be implemented for all future employees. This orientation will ensure that all mandatory training is completed prior to commencement of employment. This will be monitored with the assistance of the new office assistant.

**Proposed Timescale:** 30/05/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Systems for the management and recording of residents fees, monies paid to the provider and kept in the centre for safekeeping were not transparent to ensure residents were safeguarded.

The person in charge stated that she did not know what arrangements were in place for invoicing of residents as she had no involvement with management of finances. There were no records available in the centre.

Small amounts of money were kept for safekeeping on behalf of a number of residents. There were no signatures recorded for some transactions. Receipts were not available for all amounts withdrawn including items such as hairdressing.

13. **Action Required:**
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

**Please state the actions you have taken or are planning to take:**
The current Provider has reviewed this system and agrees that a new robust system needs to be put in place to manage residents monies. Going forward residents will be invoiced monthly for all services provided such as hair dressing, chiropody, prescription fees. There will be one payment to the provider and this will reduce the money transactions between residents’ and staff. A book is maintained in the office for any monies received at the center and a receipt given

A copy of an invoice which is sent monthly is attached to indicate how these services are to be charged in future and avoid the need for monies to be stored on site

The system in place for small amounts of pocket money shall remain in place and records will be in line with current regulations, receipts shall be issued for all transactions. This will be discussed further at the residents meeting on the 13.04.2017.
Proposed Timescale: 30/04/2017

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:
All risks had not been identified and assessed.

Measures identified to control some risks were not in place. For example, 'an enclosed back garden for residents to wander safely in' was included as a control measure in place to reduce the risk of resident absconion and 'medication trolley stored in the treatment room when not in use which has a key coded entry system' was included as a control measure in place to reduce the risk of medication error. The control measures mentioned were not in place.

Risks associated with the use of hoists, clinical waste, needle stick injury, cleaning chemicals, defective garden furniture had not been assessed and included.

Cleaning chemicals in use were stored in unlabelled spray bottles which posed a risk to residents, staff and visitors.

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:
Risk assessment is an ongoing area, however the Current Provider and the PIC have reviewed the risks identified have completed these immediately.

The over all risk register will be an ongoing document. Staff will be encouraged to add to the register accordingly. Staff will be asked at report every Monday morning to identify an area of risk that requires assessment and action. They will be encouraged to identify the concerns and offer suggestions on how to control the risk. This can then be updated and entered into the Risk Register as part of the daily routine of either the Nurse on duty or the PIC. Staff will then feel comfortable identifying risks and be involved with the management and review of same.

Due to the appointment of the CNM and the Office assistant, the PIC will ensure that this area is given close attention going forward

Work has commenced on the back patio in order to make a safe, enclosed area for residents to enjoy the views on offer, this will be completed by the 01.05.2017
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The same cloth was being used to clean a number of rooms contrary to best practice. The cleaning staff on duty told the inspector that there were insufficient cloths available.

Cleaning equipment including clean cloths and mop heads were being stored in the sluice room adjacent to a bed pan washer which posed an infection control risk.

15. 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:
Infection control training has taken place and has been completed. A cleaning Trolley, cloths and pedal bins have been ordered and received since the inspection

The cleaning company have provided us with Data Sheets for our Risk Assessments which provide all the information required in order to understand what the product contains and how to use it appropriately.
These are stored within the cleaning room for staff to be able to access when required.

There has been an area identified which would be more suitable for storage of cleaning equipment, the practice of leaving this equipment in the sluice room has now stopped, following Infection Control Training

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The last fire drill took place in May 2016 and included outcomes and follow up actions. The person in charge informed the inspector that there had been no recent fire drill.

16. 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 organise an unannounced Fire drill and this is planned before the end of March.
Fire Drills will be carried out every 6 months and findings will be recorded.

**Proposed Timescale:** 01/04/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire safety training had taken place twice in 2016 however, the inspector noted that many staff had not received training in 2016 and new staff members had not received any training. This was brought to the attention of the person in charge on the morning of the first day of the inspection. She immediately arranged fire safety training for the afternoon of that same day. She confirmed that all staff with the exception of two had up to date training.

17. **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:
The safety of the residents is of great importance and a high priority within the care that we provide. All fire training is now up to date and will continue as per best practice going forward.
This will be monitored regularly by the PIC and the current provider

**Proposed Timescale:** 29/03/2017

**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:**
While there was evidence of regular review of care plans, the inspector noted that some residents had been recently reviewed by the SALT and OT, however, the recommendations had not been updated in residents care plans. The recently changed needs of another resident had not been clearly updated in his care plans.
18. **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:**
All care plans will be reviewed and updated to include the areas above. With the help of the new administration structure, and the appointment of the CNM, this area can now be monitored more closely.

Nurses have been instructed to use the system of the communication diary. The Practice of using the communication diary at handover to ensure that things such as SALT and OT updates are not forgotten and are entered in a timely manner.

Residents have been divided into groups with a named nurse. This nurse is responsible for ensuring that all care plans are updated as required and at least on a 4 monthly basis. A care plan review monthly assessment log has been introduced for each resident and is in place in each folder to remind nurses of when care plan and assessment review is due.

It is the responsibility of the CNM and the PIC to audit this area and ensure that this practice is adhered to.

**Proposed Timescale:** 29/03/2017

### Outcome 12: Safe and Suitable Premises

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There a glass door to one bedroom. While the door had been fitted with opaque glass and a net curtain, the inspector noted that the privacy and dignity of the resident using this bedroom was compromised.

There was no bath provided therefore had no choice of bath or shower. There were three doors leading into some of the toilets which potentially posed a risk to the privacy and dignity of residents.

There was no separate cleaners room, this posed an infection control risk.

There was no secure accessible external space provided for residents. There was a paved external patio area accessible from the main day room, however, this area was not secure, the garden benches were defective and the metal support provided to the hand rail at the ramp leading to the area was rusted and defective.
19. **Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
Frosted Contact has been placed on the glass door and this with the lace ensures that privacy and dignity is maintained immediately
The glass door is to be replaced 01.04.17

The outside area is currently under construction to ensure safety of residents. 01.05.217

There has been an area provided for the cleaning room. Immediate

The bathroom that has 3 doors is currently being reviewed by the current provider in order to decide the best course of action 01.05.17

**Proposed Timescale:** 01/05/2017

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff spoken with confirmed that they had received one days orientation but had not received comprehensive induction or training. There were no records of induction training completed maintained on staff files. The policy on staff training and development outlined that staff should complete a 12 week induction programme as part of their probationary employment and that the induction training booklet would be signed by the person in charge when the staff member had demonstrated a sound basic understanding of a variety of subject areas. This was not happening in practice.

As discussed under Outcomes 7, 9 and 11 all staff did not have up to date training in fire safety, manual handling, infection control, safeguarding and medicines management.

20. **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 area of orientation and training is currently under review as stated above. A new orientation programme is to be devised and rolled out to any future employees. Again, the support of the office assistant and the new CNM will allow the PIC to monitor
this area closely
Training has already been completed since the inspection to include the areas mentioned. Signature sheets attached
The Provider will also ensure that it is monitored.

**Proposed Timescale:** 01/05/2017