<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Ursula's Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000171</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Golf Links Road, Bettystown, Meath.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>041 982 7422</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:seamus.sarsfield@stursulas.ie">seamus.sarsfield@stursulas.ie</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>Ballyhavil Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Seamus Sarsfield</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
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<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>23</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: To:
27 September 2017 09:00 27 September 2017 17:00
28 September 2017 08:30 28 September 2017 14:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
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<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 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 16: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</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 was an announced inspection completed over two days to inform renewal of the centre's registration with the Health Information and Quality Authority (HIQA). The inspector also followed up on progress with completion of four action plans required from the previous inspection in January 2017. These action plans had been progressed but were not satisfactorily completed and are restated in the action plan with this inspection.

The inspector met with the provider representative, person in charge, operations manager, members of the staff team and residents and their relatives during the course of the inspection. Documentation records such as the centre's policies, risk management (including fire safety) procedures and records, audits, staff training records and residents' records were reviewed.

Residents and relatives spoken with during this inspection and feedback from pre-
inspection questionnaires completed by three residents and four relatives referenced satisfaction with the service provided, care given and the staff team in the centre. Residents confirmed that they felt safe and were well-cared for in the centre. A summary of feedback from residents and their relatives as received by the inspector was communicated to the provider representative and person in charge during the course of the inspection.

The provider and person in charge held responsibility for the governance, operational management, administration of services and provision of sufficient resources to meet residents' needs. There were appropriate systems in place to manage and govern the service and the areas for improvement which were identified by the inspector had already been identified and actioned by the provider. There were arrangements in place to ensure residents were appropriately safeguarded and all staff were appropriately vetted. There was evidence that residents were consulted with and that their views were valued and their choices were respected.

Residents' accommodation was arranged over two floor levels. The centre was visibly clean and was maintained to a good standard. The provider was in the process of addressing aspects of the layout and space provided in residents' communal accommodation and accessibility to the first floor to ensure the centre met its stated purpose. The inspector found that residents had sufficient space for their personal belongings in their bedrooms.

Residents' healthcare needs were met to a satisfactory standard. Staff were knowledgeable regarding residents and their needs. However improvements were required in residents' care planning documentation. Recreational activities available for residents were interesting and meaningful. However, limited communal facilities and staffing resources did not ensure that residents' activation needs were met. While a number of staff had not attended mandatory training, this training was scheduled for dates in the weeks following the inspection. Staff were facilitated to attend professional development training to enhance their skills and knowledge.

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

### Outcome 01: Statement of Purpose

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The centre's statement of purpose was updated in September 2017 and forwarded to the Health Information and Quality Authority (HIQA). This document described the service that is provided in the centre. All matters listed in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were included in the statement of purpose document.

**Judgment:**
Compliant

### Outcome 02: Governance and Management

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a clearly defined governance and management structure in place that identified lines of authority and accountability. The roles and responsibilities of all members of the management and staff team were outlined. The provider, person in
charge and the operations manager met on a monthly basis. The minutes from these meetings were made available to the inspector.

The provider gave assurances and demonstrated that actions were being progressed to address the areas of the premises that were not in compliance with the regulations and standards. The inspection findings evidenced that management and staff took a proactive approach to ensuring quality and safety of the service but a number of areas of the service required improvement. For example, actions required from the last inspection in January 2017 to ensure residents' activation needs were met and that sufficient staffing resources were provided were not satisfactorily completed.

There was a system in place for monitoring the quality and safety of the service. The provider and management team had reviewed the system used and had identified areas needing improvement to ensure the process was comprehensive. This concurred with the inspector's findings that audits were completed and mostly analyzed. Although some improvement plans were developed identifying areas for improvement and were actioned, improvement plans were not consistently developed or closed out.

Judgment:
Non Compliant - Moderate

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**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:**
A Residents’ Guide was available in the centre. The guide was available to residents and contained all of the information required by the Regulations.

Each resident had a written contract for the provision of services that was agreed on their admission. The inspector reviewed a sample of contracts and found that they dealt with the care and welfare of residents while in the centre outlined the services to be provided and the fees to be charged to the resident. Additional fees were also detailed in each case. Residents signed their own contracts as confirmation of their agreement with the terms of their residency in the centre in the most of the sample of contracts examined by the inspector.

Judgment:
Compliant
**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:**

The centre was being managed by a suitably qualified and experienced nurse in care of older people. The person in charge recently commenced in the role of person in charge of the centre. She demonstrated that she had authority and was accountable and responsible for the provision of the service to residents. The person in charge also demonstrated that she was engaged in the governance, operational management and administration of the centre on a full-time basis over five days each week. She was supported in her role by nurses, care assistants, administration, maintenance, kitchen, laundry and housekeeping staff who reported directly to her. An operation manager worked in the centre one to two days each week.

The person in charge is a registered nurse with An Bord Altranais agus Cnámhseachais Na hÉireann. She has completed a number of postgraduate management course and other courses and training to maintain her professional development. She demonstrated that she had knowledge of the Regulations and Standards pertaining to the care and welfare of residents in the centre. She has the required experience in caring for dependent people and worked as person in charge of a residential care facility previously. The person in charge had sufficient clinical systems in place to ensure residents were provided with a high standard of care. She met with the staff team on a regular basis. Information required was easily accessed and well organized.

The person in charge had a detailed knowledge of each resident's life history, condition and care needs. Staff spoken with by the inspector confirmed that there was good inter-team communications. Pre-inspection questionnaires completed by residents and their relatives confirmed that the person in charge consulted with them, was approachable, listened to them and addressed the issues raised by them. Residents spoken with by the inspector knew who the person in charge was and told the inspector that they felt she 'genuinely cared' about them and that they were always confident 'she would sort out any problems or worries' they had.

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

Findings:
All information as required by Schedule 2 of the Regulations was available in the sample of staff files examined.

A directory of residents with all details as required by Schedule 3 of the Regulations was maintained.

There was evidence that emergency evacuation drills were completed to test day and night-time staffing resources and conditions. However, the details of the drills as recorded did not comprehensively inform all aspects of the procedure as required in Schedule 4, Paragraph 10 of the Regulations.

Other records to be maintained in respect of each resident and otherwise as described by Schedules 3 and 4 of the Regulations were in place and were stored securely.

All operational policies as required by Schedule 5 of the Regulations were available and up to date. These policies were accessible to staff to inform and guide their practice.

Judgment:
Compliant

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

Theme:
Safe care and support

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

**Findings:**
Arrangements were in place to ensure residents were safeguarded and protected from harm or abuse. There was a policy available informing the procedures in place to ensure residents were not abused. While, staff training records indicated that 17 staff had not completed up-to-date mandatory training on prevention, detection and response to abuse, training for these staff was scheduled in the weeks following the inspection. A number of staff spoken with by the inspector were knowledgeable about how to identify, report and respond to abuse. They were aware of their responsibility to report and confirmed that there were no barriers to raising issues of concern. Residents confirmed in pre-inspection questionnaires and to the inspector during the inspection that they felt safe in the centre.

A policy and procedure was available to inform restrictive procedures and practices and a restraint-free environment was promoted in the centre. Bedrails were in use by eight residents, some of which were requested by them. The records of bedrail use demonstrated on-going reduction in the number of bedrails used. There was evidence that use of bedrails was informed by an assessment of need. Bedrail risk assessments to ensure suitability of use were completed. The person in charge confirmed that hourly bedrail safety checking and regular removal procedures were completed, however these procedures were not recorded in residents' records. This finding is actioned in outcome 5. While PRN (a medicine only taken as the need arises) medicines were not administered to any residents at the time of this inspection, arrangements were in place for review of use to ensure it was appropriate in each case.

The inspector was told that four residents were predisposed to episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Assessments had been completed and were used to inform behavioural support care plans for these residents. The inspector’s observations on inspection and examination of residents’ documentation confirmed that residents predisposed to responsive behaviours were effectively supported. The information recorded in residents’ behaviour support care plans identified the responsive behaviours, the triggers to the behaviours and the most effective person-centred interventions to be used to de-escalate any episodes. Residents were referred appropriately to the psychiatry of older age services. Some staff had completed training in care of residents with responsive behaviours and training was scheduled to ensure all staff will have completed this training by the end of 2017.

The provider was an agent for collection of a two residents’ social welfare pensions. The information provided and documents examined indicated that the provider operated as an agent in line with the guidelines issued by the Department of Social Protection. The systems in place were also subject to audit. The provider representative also confirmed that statements of residents’ accounts were available to residents or their relatives on their behalf. The centre held small amounts of money in safekeeping for some residents’ day to day expenses. This money was kept in a locked safe and was available to them as they wished. A record was maintained of all lodgements and withdrawals. The inspector checked a sample of documented balances against money held and found them to be accurate in each case. Entries were signed by the resident where possible.
and otherwise by two staff. The system in place was found to be sufficiently robust to protect residents and staff.

**Judgment:**
Substantially Compliant

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### 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

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

**Findings:**
There were systems in place to ensure the health and safety of residents, staff and visitors was promoted and protected. An up-to-date safety statement was available for the centre. The required information regarding the management of specified areas of risk as outlined by Regulation 26 was described to protect vulnerable residents. Internal and external hazards were identified with controls specified to mitigate risk of adverse incidents to residents, visitors and staff. This document was a frequently reviewed and updated as necessary. Areas in the centre that were potentially hazardous were secured with measures in place to control access by unauthorized persons.

A proactive approach to risk management in the centre was demonstrated. A record was maintained of incidents and accidents involving residents, staff and visitors. Each incident was reviewed by the person in charge and discussed at the monthly management meetings attended by the provider representative, person in charge and the operations manager. Areas for improvement and learning from incident reviews were documented and implemented in practice. There was an effective falls prevention process in place for residents. The records examined referenced a small number of incidents where residents had falls resulting in an injury that required hospital care. The centre's physiotherapist attended the centre two days each week and was involved in promoting residents' safe mobility. Each resident has a risk of fall assessment completed on their admission that was regularly updated thereafter including after any fall or near-miss incident. Low level beds, floor mats, hand rails in corridors, toilets and showers, staff supervision, sensor equipment and education on prevention were some of the measures utilized to reduce risk of fall or injury to vulnerable residents.

Arrangements were in place to protect residents and others from risk of fire in the centre. All residents had evacuation risk assessments completed that clearly indicated their day and night-time evacuation needs in terms of staffing and equipment. This information also considered any other factors that could potentially hinder timely evacuation of individual residents such as impaired cognition. Fire safety management checking procedures were in place, Although service records for the fire panel, alarm,
emergency lighting and directional signage were in place, records recording routine checking procedures to ensure function of the fire alarm and fire doors and emergency lighting were incomplete. Designated fire exits were indicated and a checking procedure was in place to ensure they were free of any obstruction on a daily basis. Equipment including fire extinguishers were available at various points throughout the centre and were serviced annually. There was evidence that emergency evacuation drills were completed to test day and night-time staffing resources and conditions. However, the details of the drills as recorded did not comprehensively inform all aspects of the procedure as required in Schedule 4, Paragraph 10 of the Regulations. This finding is actioned in outcome 5. Staff spoken with by the inspector were aware of the emergency procedures in the event of a fire occurring in the centre. While all staff had participated in an emergency evacuation drill, the staff training records examined indicated that nine staff did not have up-to-date fire safety training. The person in charge and operations manager informed the inspector that training was scheduled for these staff in November 2017.

An infection control policy was available to inform and guide staff on management of communicable infection and any infection outbreak in the centre. Environmental cleaning procedures reflected best practice in infection prevention and control standards and the centre was visibly clean. Hand hygiene facilities and personal protective equipment (PPE) was located at various points throughout the premises.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective care and support

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

Findings:
Residents healthcare needs were met to a satisfactory standard. Residents had access to their general practitioner (GP), community psychiatric and palliative care services as necessary. Residents also had access to allied healthcare professionals including dietetic, speech and language and occupational therapy services. Residents were supported to attend out-patient appointments as necessary. A physiotherapist was employed by the provider as part of the service provided for residents in the centre. The physiotherapist
worked with residents in the centre on two days each week completing their assessments and treatments to optimize their mobility and independence. The physiotherapist also facilitated a chair-exercise activity for residents two mornings each week.

All residents had a comprehensive assessment of their needs completed on admission and their care plans were developed based on the information gleaned from these assessments. Residents' care plans were updated thereafter in response to any changes in their health and wellbeing. However recommendations made by the physiotherapist were not consistently documented in some residents' care plans. Staff were observed by the inspector to be responsive to residents' needs and provided person-centred care to meet their individual needs. While the sample of care plans examined by the inspector were person-centred, improvements were necessary to ensure that the care interventions that staff must complete to meet residents' needs were clearly stated. Records reviewed and feedback from residents and their relatives in pre-inspection questionnaires confirmed they were involved in their care plan development and subsequent reviews.

There were no residents with pressure-related skin ulcers that occurred in the centre. Woundcare procedures for two residents with other wounds were reviewed on the day of inspection. Comprehensive wound monitoring procedures and treatment plans were in place. Residents at risk of developing pressure related skin ulcers had risk assessments completed with associated treatment plans to inform their care. Prevention care plans were in place for residents identified as being at increased risk of developing pressure related skin ulcers. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate the risk of pressure ulcers developing.

**Judgment:**
Substantially Compliant

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**Outcome 12: Safe and Suitable Premises**
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

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

**Findings:**
Aspects of the centre's layout and design did not meet its stated purpose to a sufficient
standard due to the following findings. There were insufficient communal facilities to meet residents' collective needs. Residents' communal accommodation in the centre consisted of a dining room, a sitting room, a small conservatory area and a smokers' room. The sitting room was used at lunchtime as a dining area for residents resting in assistive chairs and residents who needed assistance with eating. The sitting room was used for residents' activities in the morning and afternoon periods. This arrangement did not ensure residents who wished to rest and relax in this room could do so. There were high noise levels in the room especially on the evening of the first day of the inspection. Two residents told the inspector that they were uncomfortable with the level of noise in the room which they confirmed occurred frequently. A small conservatory was available and was favoured by three residents. This room did not have sufficient space for more than these three residents.

Seven single residents' bedrooms were located on the first floor. An assisted bath, shower and toilet were available for their use. A stair-lift was provided in the absence of a passenger lift between floors. As the stairs was identified as posing a risk of falls to some residents on the ground floor, a key code lock was fitted on the door accessing the stairs on the ground floor to control access to the stairs and stair-lift. Residents were assessed by a physiotherapist to ensure their safety using the stairs and stair-lift as necessary. One of the seven residents could independently access their bedroom on first floor. The other six residents required the assistance of staff to safely access their bedrooms. Staff were observed to make every effort to assist residents as they wished to return to their bedrooms on the first floor. While one resident accommodated on the first floor acknowledged the efforts made by staff, they told the inspector they had to wait for assistance at times.

The arrangement where windows fitted with frosted glass were located in the ceilings of residents' bedroom accommodation on the first floor required improvement to provide residents with an opportunity to view their external environment. These windows could be opened to allow for ventilation but as the glass was frosted it was not possible to see through them.

The provider advised the inspector that he had recognized that the design and layout of the centre required improvement and was progressing a refurbishment plan to enhance the quality of life for residents in the centre with additional internal and external communal space. A proposed refurbishment and extension to the current premises was in the final stages of preparation for submission for planning approval.

The centre currently has bedroom accommodation for 24 residents over two floors. All bedrooms are single occupancy. Seven bedrooms were located on the first floor and the remainder were located on the ground floor. Although the floor space in some bedrooms was limited, they provided adequate space to meet the needs of residents residing in them. Each bedroom had a television and adequate storage facilities. Bedroom doors were covered with a transfer image that resembled a domestic front door. Each door was different and the door transfer fitted was done in consultation with each residents.

The centre fabric was brightly painted and well-maintained. Call bells were in place in bedrooms, toilets and bathrooms. Assistive equipment was available to residents that
required support, which were found to be stored in designated areas when not in use.

**Judgment:**
Non Compliant - Moderate

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

**Findings:**
Although the management team and staff promoted the rights and privacy and dignity of residents, the limitations of the premises described in Outcome 12 impacted on residents ability to make choices about how they live their lives in a way that reflects their individual preferences,

Residents were consulted with and supported to participate in the organization of the centre. A monthly residents' meeting was convened and some residents spoken with by the inspector were aware of the plan to refurbish the premises. The meetings were well attended and were minuted. Suggestions made by residents were welcomed and any issues they raised were addressed. Residents had access to an advocacy service.

While efforts by all members of staff were made to ensure residents' privacy and dignity was respected, this was compromised by insufficient communal facilities to facilitate residents who wished to rest and relax in the sitting room. Two residents told the inspector that their comfort was compromised by the noise levels in the communal sitting room. The sitting room was noisy as it was used as the venue for all group activities and to accommodate residents with increased supervision and assistive needs during mealtimes. An alternative conservatory area which comfortably accommodated a maximum of three people was provided but was not available to most residents on the day of inspection. The inspector observed that this small conservatory area was fully occupied at all times throughout the day of inspection by other residents. As the dining room did not provide adequate space for all residents to dine together in one sitting at mealtimes, residents resting in assistive wheelchairs and needing assistance with eating dined in the communal sitting room. This arrangement did not ensure residents who were unwell or wished to relax and rest in the sitting room during mealtimes could do so comfortably. Residents dining in the sitting room were also interrupted by other
residents returning from having their meal in the dining room. These findings are also discussed and actioned in outcome 12.

Access through the centre’s exit doors was controlled by staff. Residents had access to a small enclosed outdoor area. The door providing access to residents' bedroom accommodation on the first floor had a keycode lock fitted to ensure residents assessed as being at risk of falling did not access the stairs or stair-lift unaccompanied. One resident accessed the first floor independently, While the other six residents could mobilize independently while on the ground floor, they could not independently access their bedrooms on the first floor without assistance from staff. These arrangements did not promote these residents' independence and freedom to access all areas of the centre at will. The inspector observed that staff worked to ensure each resident's privacy was respected. All residents were accommodated in single bedrooms. Staff were observed knocking on bedroom and toilet or bathroom doors before entering. Privacy locks were in place on all bathroom and toilet doors. Bedrooms, toilets and bathroom doors were closed by staff during all personal care activities.

Residents were facilitated to exercise their civil, political and religious rights. Staff sought the permission of residents in the centre before undertaking any care tasks and consulted with them about how they wished to spend their day and care issues. Residents spoken with by the inspector expressed their satisfaction with the service and care they received in the centre. Residents' wishes and preferences also informed their daily routine regarding the times they retired to bed and got up in the morning. Residents visitors' were welcomed to the centre. There were no restrictions on visitors and a number of residents had visitors during the days of this inspection. The inspector observed one resident meeting their visitors for refreshments in the dining room.

The inspector observed that while the quality of activities provided and assessment of residents' activity needs was improved since the last inspection in January 2017, further improvement was necessary to ensure the residents' activation needs were sufficiently met. Activities were organized and facilitated by an activities coordinator. The inspector was informed that meeting residents' activation needs was an integral part of the role of care assistants working in the centre. The activity coordinator worked four days each week. There was an arrangement in place that care staff would assist the activity coordinator on four days and facilitate activities organized by the activities coordinator on the fifth day each week and at weekends. However the findings of inspection confirmed that this arrangement was not feasible as the care assistants were busy with assisting residents with their individual care needs and unavailable to assist with scheduled activities. This arrangement did not ensure residents' activation needs were sufficiently met. This finding is discussed and actioned in outcome 18. The inspector observed a horoscope reading activity facilitated by the activity coordinator for a small group of residents. This group of residents were engaged and clearly enjoying the activity. The other residents in the sitting room were not engaged in the television programme provided for them and many were sleeping. A music session in the afternoon where the facilitator played music chosen by individual residents was enjoyed by most residents. Some residents spoken with by the inspector confirmed they enjoyed the activities facilitated for them most of the time but some also commented that 'the day was long' and that their participation in activities was compromised by the noise levels in the sitting room. One-to-one activities a number of times each week and a
sensory-based programme on one afternoon each week was provided by the activity coordinator for residents unable to participate in group activities. Each resident’s activation needs was assessed and was informed by their life history and interests before coming to live in the centre. While records were maintained regarding each resident’s participation and level of engagement. However some improvement in the detail of the information recorded to reference the activities each resident participated in was necessary to ensure they met their individual interests and capabilities.

**Judgment:**
Non Compliant - Moderate

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### Outcome 18: Suitable Staffing

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

**Theme:**
Workforce

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

**Findings:**
There was an actual and planned staff rota in place, which reflected the staff numbers on duty on the day of this inspection. There was evidence that staff numbers and skill levels were reviewed since the last inspection in January 2017 to ensure they adequately reflected the assessed needs of residents. However, the findings of this inspection confirmed that the staffing levels provided were not adequate to ensure residents’ social and activation needs were comprehensively met. This finding is repeated from the last inspection in January 2017. Recreational activities for residents on three days each week were organized by the activity coordinator to be facilitated by care staff in her absence. The inspector’s findings confirmed that care assistants were busy with meeting residents’ individual care needs on both days of the inspection and as not facilitated with dedicated time to assist the activity coordinator or to facilitate the activities organized for residents in the absence of the activity coordinator. Care staff were also required to undertake laundry duties in addition to their role in meeting residents’ personal care needs on one day each week in the absence of designated laundry staff.

The person in charge completed staff appraisals which were also used to inform staff training and professional development.

Mandatory staff training was facilitated. Although not completed for all staff at the time.
of inspection, training in safe moving and handling procedures, fire safety and safeguarding residents from abuse was scheduled for dates in the weeks following this inspection. The inspector observed that all moving and handling procedures involving residents were completed safely and reflected evidence based practice. Staff spoken with by the inspector were knowledgeable regarding fire safety procedures in the centre and safeguarding residents from abuse. Staff were facilitated to attend training programme to support them with providing evidence based care to residents.

The provider representative confirmed that all staff working in the centre had An Garda Síochána vetting procedures completed. The inspector examined a sample of staff files which were found to contain all of the information required by Schedule 2 of the regulations including completed An Garda Síochána vetting procedures.

**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:**

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Ursula's Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000171</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27/09/2017</td>
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<tr>
<td>Date of response:</td>
<td>09/11/2017</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme: Governance, Leadership and Management

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

Although some improvement plans were developed and progressed to address areas for improvement, action plans were not consistently developed or closed out.

1. 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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The RP & PIC acknowledge that while improvements to Governance systems are recognised by the Authority, the systems are not yet fully established, effective or implemented in accordance with Regulation 23(c).
A more thorough analysis of audits, actions taken, lessons learned and improvements required will be implemented. Audit templates will be reviewed to ensure action needed is implemented, follow up and close out will be more robust and comprehensively analysed for its effectiveness at each monthly Governance meeting.
The RP & PIC are fully committed to improving & developing effective monitoring processes & improving the audit cycle for its effectiveness.

Proposed Timescale: 31/12/2017

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:
Staff training records indicated that 17 staff had not completed up-to-date mandatory training on prevention, detection and response to abuse.

2. 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 have received training on prevention, detection and response to abuse. On further review of staff files only 11 staff are due to complete up-to-date training in November 2017.

Proposed Timescale: 30/11/2017

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:
Although service records for the fire panel, alarm, emergency lighting and directional signage were in place, records recording routine checking procedures to ensure function of the fire alarm and fire doors and emergency lighting were incomplete.
3. Action Required:
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

Please state the actions you have taken or are planning to take:
Records recording routine checking procedures to ensure function of the fire alarm and fire doors and are now completed on a weekly basis following a check completed by the PIC. The emergency lighting is routinely checked every 3 months by Apex Fire Limited and is documented in the fire register.

Proposed Timescale: 08/11/2017
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While all staff had participated in emergency evacuation drills, the staff training records examined indicated that nine staff did not have up-to-date fire safety training.

4. 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 have completed training in Fire Safety. The remaining nine staff are due to complete up to date training on 11th December 2017.

Proposed Timescale: 11/12/2017

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 the sample of care plans examined by the inspector were person-centred, improvements were necessary to ensure that the care interventions that staff must complete to meet residents’ needs were clearly stated.

5. 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:**
The PIC is currently reviewing all care plans with residents, family members and nursing staff to ensure the care interventions documented reflect the actual person-centred, individualised care provided to residents by staff. This is an ongoing process which will be reviewed during the monthly Governance meetings. Care planning training is organised throughout the month of November and December.

**Proposed Timescale:** 31/12/2017

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Recommendations made by the physiotherapist were not consistently documented in some residents' care plans.

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

**Please state the actions you have taken or are planning to take:**
The physiotherapist documents her recommendations in the residents main file which includes the residents care plan. A report on each resident reviewed is produced weekly and a handover to all staff is given by the physiotherapist. Going forward, all recommendations made the physiotherapist will be documented directly into the residents care plan by nursing staff as required by Regulation 5 (2).

**Proposed Timescale:** 01/12/2017

**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:**
Aspects of the centre's layout and design did not meet its stated purpose to a sufficient standard.
* insufficient internal and external communal facilities to meet residents' collective needs
* 6 residents did not have free access to their bedrooms on the first floor
* Windows in bedrooms on the first floor, which were placed in the ceiling had frosted glass and residents could not see outside when in their bedrooms.

**7. 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
Please state the actions you have taken or are planning to take:

The RP is eager to comply with Regulation 17 (1) and in doing so has put the following plans in place:

* As per standard 2.7.4 communal space provided should be a minimum of 4 square metres for each resident. Currently, we provide 4.3 square metres per resident. We acknowledge that the space we have could be utilised more effectively to ensure residents’ comfort and well-being. We have removed some of the larger furnishings in the sitting room to meet the needs of our residents.

* We have now two sittings at dinner time which facilitates the needs of all residents to ensure a relaxed dining experience.

* We are currently at the pre-planning design stage with DFK (Consulting Civil and Structural Engineers). In this submission we have included a passenger lift to the first floor. In the interim all residents residing on the 1st floor now have the code to access the door to the ground floor allowing unrestricted access to move freely around the home if desired.

* The residents residing in bedrooms on the 1st floor will be consulted with individually regarding the frosted glass in their bedrooms. Their wishes will be respected and changes made if required.

Proposed Timescale: 01/03/2018

**Outcome 16: Residents' Rights, Dignity and Consultation**

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents did not have sufficient opportunity to participate in activities to meet their interests and capabilities.

Improvement in the detail of the information recorded to reference the activities each resident participated in was necessary to ensure they met their individual interests and capabilities.

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

Please state the actions you have taken or are planning to take:
The Activities roster has increased from 23.5 hours to 36 hours over 6 days per week for residents. This will incorporate a full weekly activity planner with a variety of social, therapeutic and one to one activities to guarantee all residents preferences will be met. Daily documentation of resident participation will be more comprehensive. This will be reviewed on an ongoing basis to confirm resident participation and satisfaction with activities provided.
**Proposed Timescale:** 08/11/2017  
**Theme:**  
Person-centred care and support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Inadequate communal facilities impacted residents activation needs being met.

9. **Action Required:**  
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

**Please state the actions you have taken or are planning to take:**  
We are currently endeavouring to utilise our space more efficiently. Activity programmes are held in the main lounge area, dining room, decking area and bedrooms. There is now a more varied activity programme for residents with emphasis on their likes, capabilities and cognition. All space will be utilised at different times of the day with different recreational and stimulating activities offered to residents. In our planning submission we will plan for a new sitting room, dining area and kitchen.

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**Proposed Timescale:** 01/03/2018  
**Theme:**  
Person-centred care and support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Aspects of the environment limited residents' right to exercise choice as follows:  
* Six residents could not freely access their bedrooms on the first floor.  
* Noise levels in communal rooms impacted on residents quality of life.  
* Residents who used assistive wheelchairs and needed assistance with eating, dined in the communal sitting room. These residents did not have a choice about where they took their meals. The inspector observed that their meals were interrupted by other residents returning from having their meal in the dining room.

10. **Action Required:**  
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**  
The RP and PIC value the rights, dignity and choice of each resident.  
* We are currently at the pre- planning design stage with DFK (Consulting civil and structural engineers). In this submission we have included a passenger lift to the first floor. All residents residing on the 1st floor now have the code to access the door to the ground floor allowing unrestricted access to move freely around the home.
The HIQA inspection coincided with Positive Aging Week and extra activities were planned to celebrate this for our residents’ enjoyment. Admittedly, on one of the days of inspection a DJ was playing music and the levels were unusually high due to the audio equipment used. In future any resident who does not wish to attend the live music will be offered an alternative activity of their liking in another area.
* We now have two sittings at dinner time which facilitates the needs of all residents to ensure a relaxed dining experience. This will be continuously reviewed by the PIC to ensure meal time is a pleasant experience for our residents with the least amount of interruptions possible.

**Proposed Timescale:** 31/12/2017

### Outcome 18: Suitable Staffing

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staffing levels provided were not adequate to ensure residents’ social and activation needs were comprehensively met.

11. **Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
A new full-time Activity Co-ordinator has commenced along with our existing massage therapist and physiotherapist. This will ensure that residents’ social and activation needs are comprehensively met. This will be reviewed regularly by the PIC through auditing and resident meetings.

**Proposed Timescale:** 31/12/2017

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A number of staff had not completed mandatory training in safe moving and handling procedures, fire safety and safeguarding residents from abuse.

12. **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 remaining staff are due to complete up-to-date safe moving and handling training in November by our in-house trainer. Fire Safety training is scheduled for December and Safeguarding is planned for November.

**Proposed Timescale:** 31/12/2017