<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St. Louis Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000289</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Clonmore, Tralee, Kerry.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>066 712 1891</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:nhstlouis@eircom.net">nhstlouis@eircom.net</a></td>
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<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>Yvonne Maher</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Yvonne Maher</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>John Greaney</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

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

<table>
<thead>
<tr>
<th>Outcome</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
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<tr>
<td>Outcome 02: Governance and Management</td>
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<tr>
<td>Outcome 03: Information for residents</td>
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</tr>
<tr>
<td>Outcome 04: Suitable Person in Charge</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
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</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>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>Compliant</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
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<td>Outcome 13: Complaints procedures</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
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</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

St. Louis Nursing Home is a two storey premises based in the town of Tralee and close to amenities such as shops, restaurants and a library. The centre is provided in a building originally constructed as a dwelling but repurposed and significantly extended to the rear in order to provide residential accommodation to older people. It is a two storey premises but all residents’ bedrooms and communal rooms are on the ground floor.

Overall, residents’ healthcare and nursing needs were met to a good standard. Staff were observed interacting with residents in an appropriate and respectful manner. Staff addressed residents by their preferred names and spoke in a clear, respectful
and courteous manner. The privacy and dignity of residents was respected during care provision, and staff were seen to knock on doors before entering. Residents appeared to be well cared for and this was confirmed to the inspector by residents during conversations. Residents were supported to maintain their independence and many were seen to move freely around the corridors and in communal areas. Residents had access to GP services and to allied health services.

Some improvements were required in the area of fire safety. For example, there was no record of the quarterly maintenance of emergency lighting and some emergency lights did not appear to be functional on the days of inspection. While there were regular fire drills, there was inadequate details recorded in relation to any learning from the drills or the scenario replicated in the drill. Additionally, the fire alarm was not sounded on a weekly basis as recommended in relevant guidance. Improvements were also required in relation to staff training, including training on safeguarding and people moving and handling.

Other required improvements included:
• there were no audits of accidents and incidents
• staff references were no always verified
• contracts of care required additional detail in relation to fees for toiletries
• risk assessments prior to use of bedrails required review
• the complaints procedure did not clearly outline the independent appeals process.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 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:**
There was a written statement of purpose that accurately described the service that is provided in the centre and contained all of the information required by the regulations.

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

**Findings:**
There was a clearly defined management structure. The person in charged reported to the provider, both of whom were usually present in the centre each day from Monday to Friday. The person in charge was supported in her role by an assistant director of nursing.

There was a comprehensive programme of audits on areas such as medication management, protection, restraint, and recruitment. There were monthly meetings that
were usually attended by the provider, person in charge and assistant director of nursing. Issues discussed at these meetings included findings of audits and any required improvements. Some improvements were required in relation to the audit process. For example, there was no audit completed of accidents and incidents to identify trends as an opportunity for learning in order to minimise the risk of reoccurrence.

There was consultation with residents through residents meetings that were held on a monthly basis and through residents' surveys. There was an annual review of the quality and safety of care delivered to residents. A copy of this review was available for residents and visitors near the entrance to the centre.

**Judgment:**
Substantially Compliant

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

**Findings:**
There was a guide to the centre that was available to residents and visitors. Each resident had a written contract of care, which included details of the services to be provided and the fees to be charged. The contract addressed whether or not the resident occupied a shared bedroom, as required by the regulations. While the contract included fees for additional services, it was not clearly stated that a fee for provision of toiletries was optional and did not detail exactly what was included in this fee.

**Judgment:**
Substantially Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a person in charge of the centre who worked full time and was usually present in the centre each day from Monday to Friday. The person in charge was a registered nurse and had the required experience in nursing of the older person. During the inspection she demonstrated adequate clinical knowledge and adequate knowledge of the legislation and her statutory responsibilities.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that the designated centre had 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.

Other records listed in Schedules 3 and 4 were also maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The residents’ directory was available and was continuously updated by staff and contained all of the information required under Regulation 19.

Improvements were required in relation to the maintenance of Schedule 2 documents. While there were two written references for all staff, some references were "To whom it concerns" and were not verified.

Judgment:
Substantially 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
### Theme:
Safe care and support

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

### Findings:
There were policies and procedures in place in relation to safeguarding residents from abuse. Training records reviewed by the inspector indicated that not all staff had up-to-date training on the prevention and detection of abuse. Staff members spoken with were knowledgeable of what constituted abuse and what to do in the even of suspicions or allegations of abuse. The inspector was informed that there were no allegations of abuse. Residents spoken with by the inspector stated that they felt safe.

There was a policy on responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia). There were no residents in the centre on the days of inspection with significant responsive behaviour. Staff spoken with were knowledgeable of the communication needs of various residents and this was outlined in care plans. Training records, however, indicated that not all staff had attended training in responsive behaviour and dementia. The only form of restraint in use was bedrails. There was evidence of the use of alternatives to bedrails, such as sensor alarms and crash mats. There was not, however, an adequate risk assessment carried out prior to the use of bedrails. The risk assessment in use did not include the exploration of alternatives to restraint and did not provide adequate guidance on whether or not bedrails were appropriate and safe.

There were adequate records in relation to finances. The centre did not act as pension agent for any resident and did not keep any money for safekeeping on behave of residents.

### 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:
At the last inspection it was identified that significant improvements were required in relation to fire safety management. Many of the issues identified at that inspection have since been addressed. A review was undertaken of fire resistant doors and new doors were installed in a number of bedrooms. These had recently been fitted, however, on the first day of inspection most of them had swollen to the point where they could not be closed. This was rectified prior to the completion of the inspection and all doors could close satisfactorily. The position of the fire alarm panel was changed so that it was now more readily viewable by staff. Instructions were clearly written for staff to identify from the panel the exact location of a fire in the unfortunate event of a fire. Personal emergency evacuation plans were updated for all residents and clearly outlined the most appropriate means of evacuation in an emergency, including at night time.

Fire evacuation training had been facilitated since the last inspection and records indicated that all, except one member of care staff had attended up-to-date training. However, there were also a small number of administrative staff who did not have recent fire safety training. There were regular fire drills carried out, however, improvements were required. Records of fire drills did not contain adequate detail in relation to identifying the compartment in which the drill took place, the time of day the drill took place, the number of staff involved in the drill, or the scenario used in the drill. It was also not possible to determine from the records if a night time scenario had been replicated, for example, with only two staff members on duty and most residents in bed. Additionally the names of the staff involved in the drill were not recorded, so it was possible to determine which members of staff had participated in fire drills. This was also a finding at the last inspection.

There were records of maintenance of fire safety equipment. Fire safety equipment, including hose reels were serviced annually. The fire alarm was serviced quarterly. There was no record, however, of quarterly preventive maintenance of emergency lighting. The inspector was informed that batteries were recently changed in all emergency exit signs. However, the inspector noted that the pilot light in a number of emergency lights were not illuminated, indicating the probability that these lights were not functioning. A fire safety contractor visited the centre at the end of the inspection to service the emergency lights and certification was subsequently submitted to verify that the emergency lighting was not in compliance with the relevant standards.

There were daily checks of the fire alarm panel to ensure there were no faults and also of emergency exits to ensure they were not obstructed. The fire alarm was sounded on occasion but, according to staff, this was not done weekly as recommended, in order to determine that it functioned appropriately.

There was an up-to date safety statement. There was a risk management policy that contained all of the items specified in the regulations. There was a risk register that included a list risks for each resident and the control measures in place to mitigate these risks. The inspector was informed, however, that there was no overall risk register to identify environmental risks throughout the centre and any additional measures required, if any, to mitigate the risks identified. Combustible materials and oxygen cylinders were stored appropriately.

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

**Findings:**
Significant improvements had been made to medication management practices since the last inspection. There were operational policies and procedures relating to ordering, prescribing, storage and administration of medicines. Medication administration practices observed by the inspector were in compliance with relevant guidance. All medicines were stored securely. There was a record maintained of PRN (as required) medications held in the centre, which included a record of when and to whom it was administered. Medicines requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded. There was a record of the opening date written on liquid medications in order to identify when it should be discarded and a new one opened. There were adequate procedures in place for the return of unused and out-of-date medications.

Prescriptions were predominantly transcribed by a registered nurse and these were verified by a second nurse. Prescriptions were legible; the frequency and route of each medication was clearly written; and the 24 hour maximum dose for PRN (as required) medications was recorded.

**Judgment:**
Compliant

**Outcome 10: Notification of Incidents**

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

**Theme:**
Safe care and support

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

**Findings:**
Based on a review of accident and incident records, all notifications required to be submitted to HIQA were submitted within the appropriate timeframe.

**Judgment:**

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

**Findings:**
Residents appeared to be well cared for and this was confirmed to the inspector by residents during conversations. Residents were supported to maintain their independence and many were seen to move freely around the corridors and in communal areas.

Residents had access to GP services, including out-of-hours, and there was evidence of regular review. Residents had access to allied health services, such as physiotherapist and occupational therapist, through referral. The inspector was informed that there was a four to six week wait for this service but these services could be accessed within a shorter timeframe privately. Dietetic and speech and language therapy (SALT) services were provided by a nutritional supply company and were available on a referral basis.

Residents received a comprehensive assessment on admission and at regular intervals thereafter. Evidence based assessment tools were used for issues such as the the risk of developing pressure sores, dependency level, the risk of falling and the risk of malnutrition. There were two assessment tools used for screening for the risk of malnutrition and the result of each assessment tool frequently conflicted with the other. The person in charge was requested to review this practice in order to have one validated assessment to guide care for residents.

Care plans were developed for residents following assessments, and while sections of these care plans were generic, additional information was usually added to each one in order to provided detailed guidance on the care to be delivered to each resident. For example, from a sample of care plans reviewed there was adequate detail of the care to be provided to residents with diabetes and residents with wounds.

**Judgment:**
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:
St. Louis Nursing Home is a two storey premises based in the town of Tralee and close to amenities such as shops, restaurants and a library. The centre is provided in a building originally constructed as a dwelling but repurposed and significantly extended to the rear in order to provide residential accommodation to older people. It is a two storey premises but all residents bedrooms and communal rooms are on the ground floor. The first floor contains administrative offices and is accessible by a stairs. The centre accommodates 25 residents in 15 single bedrooms and five twin bedrooms. Three of the single bedrooms are en suite with toilet and shower and all others have a wash hand basin only.

Overall, on the days of inspection the centre was bright, clean, warm, and in a good state of repair. Communal space comprised a large sitting room that was suitably decorated and homely in appearance. There was a dining room that was adequate in size to accommodate the number of residents living in the centre. There was also a visitors' room, where residents could meet with visitors in private, separate from their bedrooms, should they so wish. Residents had access to a secure enclosed garden and were seen to avail of this on the days of inspection.

There is a kitchen where meals for residents are prepared, and staffed by dedicated kitchen personnel. Laundry facilities were provided in a separate building on the same site as the centre.

There was a programme of preventive maintenance for equipment such as hoists, beds, mattresses, and wheelchairs. There was a functioning call bell system in place within the centre. It was identified at the last in inspection that the call bell system required review to ensure that the staff are directed to the location in which assistance is required in all cases. The inspector was informed that a new call bell system had been purchased but not yet installed. There was one door that had previously been connected to the call bell system to alert staff when the door was opened. This was now disconnected and staff would no longer be alerted should a resident leave the centre through this exit. The provider was requested to put interim measures in place to monitor this exit until the new call bell system was installed.
The enclosed courtyard provided was secure and was freely accessible by residents. At the last inspection it was noted by inspectors that there was an abrupt level change of floor adjacent to the door to the enclosed external space that represented a potential trip hazard for residents due to its abrupt nature. This had been remedied and there was now a more graded slope at the exit.

A number of bedrooms had privacy locks on doors. The privacy locks on the doors allowed residents to lock the door from the inside without a key, while also providing a means to override the lock from the outside of the door in the event of an emergency. Some residents also had keys to their doors. The key locks were only used by residents when they exited their rooms and the privacy locks were used when the resident were in their rooms. Residents were assessed for their capacity to have a key to their room to minimise the risk of residents locking the door from the inside with a key.

**Judgment:**
Substantially Compliant

**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

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

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

**Findings:**
There was a complaints policy and notice in display outlining the complaints procedure. The policy and the notice did not clearly outline the independent appeals process. Staff spoken with were familiar with the procedure for receiving and recording complaints. Residents were aware of the process which was displayed at the main entrance to the centre.

The inspector reviewed the complaints log on the day of inspection, which only contained three complaints since September 2015. Subsequent to the inspection documentation was forwarded to the inspector indicating that there were other complaints recorded but had been mislaid on the day of inspection. This documentation indicated that complaints were recorded and action taken in response to address the issues raised in each complaint.

**Judgment:**
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
Staff were observed interacting with residents in an appropriate and respectful manner. Staff addressed residents by their preferred names and spoke in a clear, respectful and courteous manner. The privacy and dignity of residents was respected during care provision, and staff were seen to knock on doors before entering. Some residents that were assessed as safe to do so, had keys to their bedrooms, so that they could lock them when they exited the room.

Residents' religious preferences were ascertained and facilitated. Mass was held in the centre monthly and prayers and communion were facilitated weekly. Residents had access to radio, television and newspapers.

Residents were consulted through residents' meetings that were held on a regular basis. While there was a record of what was discussed at the meeting, the detail was scant, and frequently the record indicated that there was only one topic discussed. There was little evidence to indicate that this was used as a forum for obtaining feedback from residents and there was no documented evidence of actions to address issues raised, if any, following the meetings. The meetings would benefit from an agenda to ensure that issues important to residents are discussed, for example, the quality of food, the range of activities, or any other issues of concern to residents. Residents were also consulted through residents surveys. Surveys viewed by the inspector were predominantly positive and any areas of dissatisfaction were explored by the person in charge. This however was not documented.

There was an activities coordinator that was present in the centre on four days each week. The inspector viewed the activities timetable which included bowling, arts and crafts, quizzes, and music by an external entertainer. Residents spoken with on the day of the inspection expressed satisfaction with the available activities.

Judgment:
Substantially Compliant

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

Theme:
Workforce

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

Findings:
Staffing levels were both consistent with the assessed needs of the resident profile, and in keeping with the design and layout of the premises. The person in charge was supported by a deputy nurse manager. Systems of supervision and delegation were in place. Communication systems were in place that included daily handover meetings and regular staff meetings.

Training records made available to the inspector on the days of inspection indicated that significant improvements were required in relation to staff training. The inspector was informed that the training matrix did not accurately reflect actual completed training. Additional records were submitted to the inspector subsequent to the inspection that showed some improvements. However, improvements were still required, most notably in training on safeguarding. The training for a significant number of care staff and a small number of nurses was out of date. This action is addressed under Outcome 7. Training records indicated that not all staff had attended up-to-date training in responsive behaviour. Some staff were also overdue refresher training in people moving and handling skills. Training in infection prevention and control was scheduled to take place in the weeks following this inspection but the programme of training could be enhanced by the completion of additional training by staff in areas relevant to the care of older persons, such as dysphagia, restraint and hand hygiene.

The inspector was assured that Garda Síochána (police) vetting was in place for all staff, including for new staff before taking up their appointment. A sample of staff files was reviewed supported this assurance. While there were two written references for all staff, some references were "To whom it concerns" and were not verified.

Judgment:
Substantially Compliant
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
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<th>Centre name:</th>
<th>St. Louis Nursing Home</th>
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<td>Centre ID:</td>
<td>OSV-0000289</td>
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<tr>
<td>Date of inspection:</td>
<td>03/10/2017</td>
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<td>Date of response:</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:
There was no audit completed of accidents and incidents to identify trends as an opportunity for learning in order to minimise the risk of reoccurrence.

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 PIC will compile an audit tool specifically to recognise trends in number of accident incidents. Audits are carried out on falls and prevention need to be addressed.

Proposed Timescale: 31/12/2017

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While the contract included fees for additional services, it was clearly stated that the fee for provision of toiletries was optional and did not detail exactly what was included in this fee.

2. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
A list of toiletries etc. will be included in all Residents Welcome packs, recognising individual needs i.e. Male or Female products and agreed upon prior to admission.

Proposed Timescale: 30/11/2017

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:
While there were two written references for all staff, some references were "To whom it concerns" and were not verified.

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

Please state the actions you have taken or are planning to take:
The PIC verified a reference for the Inspector on the day of the inspection. The PIC will
in future send a reference request on a company template to all listed referees to ensure all references are verified

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

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**Outcome 07: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Training records, however, indicated that not all staff had attended training in responsive behaviour and dementia.

**4. Action Required:**
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

**Please state the actions you have taken or are planning to take:**
Training for Responsive Behaviours & Dementia was attended by all HCA’s, Staff Nurses, PIC, Catering and Household Staff.
Staff that did not attend were as follows; 1 x administrative 1 Maintenance And the Provider of Care. All staff with direct contact with Residents Care were all trained. The PIC will ensure that all those involved in the centre will attend training going forward.

Proposed Timescale: 21/09/2017 remaining 3 staff will receive training 04/12/2017

**Proposed Timescale:** 04/12/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk assessment in use did not include the exploration of alternatives to restraint and did not provide adequate guidance on whether or not bedrails were appropriate and safe.

**5. Action Required:**
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**
The PIC has compiled a new risk assessment for Restraint, outlining whether restraint was appropriate and if it’s use should be recommended. It also includes a section as to what alternatives have been explored and if the Resident is fully aware of the risks associated with there use.
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Training records reviewed by the inspector indicated that not all staff had up-to-date training on the prevention and detection of abuse.

6. 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 had training in the prevention and detection of abuse dated from 2014 to 2016. The Inspector did clearly state that staff were knowledgeable and knew what to do and Residents felt safe. Training has since been booked for 04/12/2017 to maintain the safety of our residents.

Proposed Timescale: 04/12/2017

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector was informed, however, that there was no overall risk register to identify environmental risks throughout the centre and any additional measures required, if any, to mitigate the risks identified.

7. 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:
In the Centre there are numerous daily checklists and risk assessments, the PIC will develop a risk register so that all potential risks are identified and this register will strive to avoid and reduce potential harm to all those who enter the Centre be it employees, visitors etc.

Proposed Timescale: 30/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of fire drills did not contain adequate detail in relation to identifying the compartment in which the drill took place, the time of day the drill took place, the number of staff involved in the drill, or the scenario used in the drill. It was also not possible to determine from the records if a night time scenario had been replicated, for example, with only two staff members on duty and most residents in bed. Additionally the names of the staff involved in the drill were not recorded, so it was possible to determine which members of staff had participated in fire drills.

8. 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 has compiled a new fire drill template that will require staff to sign that they have participated in a fire drill and the fire marshal will give a detailed account of how fire drill was carried out and how staff preformed at the time, it will clearly outline compartment and the scenario that was involved and will reflect if it was day or night drill. The template also included a section for residents to sign and comment on their understanding and the experience.

Proposed Timescale: 13/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no record, however, of quarterly preventive maintenance of emergency lighting. The inspector was informed that batteries were recently changed in all emergency exit signs. However, the inspector noted that the pilot light in a number of emergency lights were not illuminated, indicating the probability that these lights were not functioning.

9. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
All lighting has now been serviced and the assigned Fire Company will continue to carry out Quarterly maintenance of all fire equipment now to include emergency lighting within the centre. Daily checks are carried out of all fire exits to ensure they are clear from obstacles and in good working order; a record of these checks is kept in the fire register folder. Contract for all maintenance of emergency lighting was received on
### 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:**

It was identified at the last in inspection that the call bell system required review to ensure that the staff are directed to the location in which assistance is required in all cases. The inspector was informed that a new call bell system had been purchased but not yet installed. There was one door that had previously been connected to the call bell system to alert staff when the door was opened. This was now disconnected and staff would no longer be alerted should a resident leave the centre through this exit. The provider was requested to put interim measures in place to monitor this exit until the new call bell system was installed.

#### Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

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The door in question was fitted with a temporary alarm that sounds when the door is opened, this will sound on the pages to alert staff.
The company are sending an engineer on the 10/11/2017 to outline all areas that need inclusion in the new system; once this is completed the installation of the system will proceed over two days. The date of completion as outlined is in the event any extra equipment may be needed following review on the 10/11/2017.

**Proposed Timescale:** 20/11/2017

### Outcome 13: Complaints procedures

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The there was a complaints policy and notice in display outlining the complaints procedure. The policy and the notice did not clearly outline the independent appeals process.

12. **Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
The Complaints procedure has since been reviewed and updated to clearly outline the protocol surrounding how complaints are dealt with.

**Proposed Timescale:** 05/12/2017

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

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents' meetings would benefit from an agenda to ensure that issues important to residents are discussed, for example, the quality of food, the range of activities, or any other issues of concern to residents. Residents were also consulted through residents’ surveys. Surveys viewed by the inspector were predominantly positive and any areas of dissatisfaction were explored by the person in charge. This however was not documented.

13. **Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

**Please state the actions you have taken or are planning to take:**
A more structured residents' meeting template has been compiled, this will give residents a clearer agenda and will allow them to be more in control of the issues they would like to raise. A list of topics will be given to the residents by the PIC or the independent advocate, so that they can choose what the wish to discuss at the meeting. Also the PIC has discussed with a number of residents if they would consider chairing meetings, as some topics may not be included on the list provided to them.

**Proposed Timescale:** 04/12/2017

### Outcome 18: Suitable Staffing

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Improvements were required in staff training. For example:
- some staff were also overdue refresher training in people moving and handling skills
- a significant number of staff did not have training in infection prevention and control
- the programme of training could be enhance by the completion of additional training by staff in areas relevant to the care of older persons such as dysphagia, restraint and hand hygiene.

**14. Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

**Please state the actions you have taken or are planning to take:**
Manual handling has been completed by staff and up to date, the Matrix indicated 3 staff were not up to date, one being a student nurse that has completed same with the college. One staff member in Administration, as they would not be involved in Residents care delivery and the other staff is Activities co-ordinator is newly employed and does not assist in the moving or handling of a Resident at this time.
All staff have now completed infection control training that also included hand washing 06/11/2017.
Dysphagia training is usually carried out by the HSE and will facilitate 3-4 staff members, the PIC has been in contact with the Nutrition Company to try and arrange if in house training for all staff could be provided.
Use of Restraint was covered in detail in the Behaviours and Dementia training that has been completed.

**Proposed Timescale:** 02/01/2018 (Dysphagia)

**Proposed Timescale:** 02/01/2018