<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Caiseal Geal Teach Altranais</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0005491</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Castlegar, Galway.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>091 757 609</td>
</tr>
<tr>
<td>Email address:</td>
<td></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>Caiseal Gael Teoranta</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Richard Keane</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary McCann</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>34</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>8</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 following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 02 October 2017 15:00  To: 02 October 2017 21:00

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 02: Governance and Management</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
</tr>
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<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Substantially Compliant</td>
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<td>Outcome 18: Suitable Staffing</td>
<td>Compliant</td>
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</table>

Summary of findings from this inspection
This unannounced monitoring inspection was carried out as part of the Health Information and Quality Authority’s (HIQA’s) regulatory monitoring function to check progress on actions from the previous inspection which was carried out on in January 2017 and to monitor compliance with the Health Act 2007 (Care and Welfare of residents in Designated Centres for Older People) Regulations 2013. The inspector also considered information received by the Health Information and Quality Authority in the form of unsolicited receipt of information which related to inadequate staffing levels.. The information in the unsolicited information was not substantiated, and the inspector found that there was adequate staff to meet the needs of residents. This was confirmed by residents and staff and observation throughout the inspection. Notifications since the last inspection were also reviewed.

The centre is located approximately four miles from Galway city in the Castlegar
area. The nursing home is connected on three levels and a lift is available between all floors. The lower level consists of a kitchen, stores area, medication storage room, laundry, office space, equipment storage room and staff rest room. The second level is the ground floor and consists of 19 single bedrooms and two twin bedrooms, a dayroom, dining room, external sun terrace, meeting rooms/offices, assisted toilets, bathroom, smoking room, nursing station and visitor’s toilet. The third level consists of 15 single bedrooms, two twin bedrooms, dayroom, dining room, therapy room, bathroom, assisted toilets and a visitors’ toilet. All 38 bedrooms have wet room style en-suite toilet and shower rooms. Accessible toilets are located in close proximity to the communal areas. The building is wheelchair accessible. Screening was available in the twin rooms to protect the privacy and dignity of residents sharing. Car parking is available to the front and side of the building. The centre is suitable for its stated purpose. Externally, the grounds were landscaped with well manicured plants.

The inspector met with residents and staff members, observed practices and reviewed documentation such as staff files, complaints log, care and medical files, accident and incident log and key policies and procedures. There was a varied programme of activities and residents spoken with by the inspector stated that they enjoyed the activities. A new activities therapist had recently been appointed and he was observed to be engaging well with residents. The healthcare needs of residents were well met and residents had good access to General Practitioner (GP) services. Sitting rooms were supervised at all times and call bells were answered promptly. Some residents chatted to the inspector about the day to day service provided and stated they” were happy living in the centre, I enjoy the board games" and confirmed that the food was good. There were three actions detailed post the last inspection, two of these were complete and one relating to the provider acting as a pension agent was in 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 Standards for Residential Care Settings for Older People in Ireland.
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:
A system was in place to monitor and review the quality and safety of the care provided. An audit system was in place and regular audits were completed but there was poor evidence available of the enactment of a quality improvement plan to address deficits. This particularly related to care plans. An annual review of the quality and safety of care delivered to residents in the designated centre was in process but not complete.

Monthly management meetings were being held between the directors of the provider company. Minutes were available of these meetings and issues discussed included finances, policies, procedures, person in charge report, staffing matters, resident issues, complaints and maintenance matters. The provider representative informed the inspector that he had a meeting with the person in charge and person participating in the management of the centre on a monthly basis. These minutes were not available for review as they were kept by the person in charge who was not on duty on the day of inspection.

Judgment:
Substantially 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 has had a change of person in charge since the last inspection. She commenced as person in charge of the centre on 15 June 2017. She qualified as nurse in 1991 and has many years of experience working in elderly care. She completed a certificate in first line management in 2010.

The person in charge has continued her own professional development and had attended course in dementia care and nutritional care. Her mandatory training in safeguarding vulnerable adults and manual handling and her registration was up to date with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) were all in date.

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

Findings:
Records listed in Schedules 2, 3, and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were kept secure and were easily retrievable. However, some documentation was incomplete. There were gaps in the nursing progress notes and no initials or signature was available when some notes were crossed out.

Policies listed in Schedule 5 of the regulations were available and up to date. In the sample of staff files reviewed there was one carer who did not have two references as required by the regulations. The action from the last inspection with regard to all staff having a full employment history was addressed.
Judgment:
Substantially Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There had been no periods where the person in charge was absent from the centre for 28 days or more since the last inspection.

There are two persons identified as the persons to act as the person in charge in her absence. Both are experienced nurses who work full-time. The inspector was satisfied that these arrangements were suitable for the management of the designated centre in the absence of the person in charge.

**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:**
Measures were in place to protect residents from being harmed or suffering abuse. There was a policy on safeguarding vulnerable adults. This included information on the various types of abuse, assessment, reporting and investigation of any allegations of abuse. The training records identified that staff had opportunities to participate in training in the protection of residents from abuse. During discussion with the inspector,
some staff members demonstrated their knowledge regarding reporting mechanisms within the centre and what to do in the event of a disclosure about actual, alleged, or suspected abuse.

There was a visitors’ record located by the reception area to monitor the movement of persons in and out of the building to ensure the safety and security of residents. The inspector saw that this was signed by visitors entering and leaving the building. Residents confirmed that they felt safe in the centre and contributed this to the presence of staff day and night. Residents confirmed that staff were pleasant and treated them with respect and kindness.

The inspector discussed the needs of the current residents with the clinical nurse manager. She confirmed that currently they had one resident who displayed responsive behaviour. She described how they manage responsive behaviour with the use of behaviour monitoring logs and the development of a behaviour management plan. The inspector reviewed the behaviour management plan and found that it required review to ensure that all staff was aware of the approach to take to manage the responsive behaviour as there was not a clear reactive strategy as to how to manage to behaviour expressed.

Restraint practices were regularly reviewed. A policy on enabler/restraint use was in place to guide practice. There were risk assessments completed for residents who had bed rails in place. Assessments gave consideration of the risks associated with the use of the restraint measure. The clinical nurse manager described the function of some of the bedrails and how they enabled residents to have a greater independence for example turn unaided in bed. However, there were no care plans in place detailing the enabling function of the bedrail.

Judgment:
Substantially Compliant

**Outcome 08: Health and Safety and Risk Management**

The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

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

**Findings:**
Service records reviewed confirmed that the emergency lighting and fire alarm system were serviced regularly. The inspector noted that fire exits were unobstructed. Ski sheets were in place for all immobile residents. Review of the fire training records showed that all staff had undertaken training in fire safety and staff spoken with by the inspector were clear as to how they would evacuate residents. Fire evacuation notices
were in place throughout the centre detailing the route to the nearest exit.

Fire drills were being completed regularly but records did not provide a comprehensive record as to whether a full or partial evacuation had been completed, what time it took to evacuate and whether there were any impediments to safe evacuation identified. No fire drill had been completed simulating a night duty scenario when the fewest staff were on duty.

A safety statement was in place. The risk management policy was reviewed and found to comply with regulation 26 of the care and welfare regulations. A centre specific risk register was in place. Where a risk was identified, they were evaluated and controls were put in place to mitigate the risk.

Training was provided to staff in the safe movement and handling of residents. There was safe floor covering and handrails throughout the centre. There was a policy in place for the prevention and control of infection. There was access to supplies of gloves, and staff was observed using the alcohol hand gels which were available throughout the centre. Arrangements were in place to review accidents and incidents. Residents at risk of falling were assessed using a validated fall assessment tool. The outcome of these assessments was communicated to all staff and a care plan specific to the identified falls risk was in place. Falls diaries were completed. Evidence was available that post-fall observations, including neurological observations, were undertaken to monitor neurological function after a possible head injury as a result of a fall.

Judgment:
Substantially Compliant

Outcome 09: Medication Management
*Each resident is protected by the designated centre’s policies and procedures for medication management.*

Theme:
Safe care and support

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

Findings:
There were written policies and procedures in place governing the management of medications in the centre. The inspector observed medication administration practices and was satisfied that they were in compliance with relevant professional guidelines. Prescription and administration records contained appropriate identifying information including residents’ photographs and were clear and legible. Where medication was required to be crushed this was prescribed as safe to administer in this format. Controlled drugs were stored appropriately and records were available demonstrating that they were counted at the end of each shift.
### Outcome 10: Notification of Incidents
_A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector._

**Theme:**
Safe care and support

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

**Findings:**
The inspector noted that a record of all accident and incidents was maintained. Where incidents were deemed as requiring notification to HIQA, this was completed but not within the required timeframe.

**Judgment:**
Substantially Compliant

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

**Theme:**
Effective care and support

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

**Findings:**
There were 34 residents in the centre on the day of inspection. Ten residents were assessed as having maximum dependency needs, 18 had medium and six were low dependency. There were no residents with pressure wounds at the time of this inspection. The inspector found that the healthcare needs of residents were met. Residents had good access to general practitioner, allied health professionals, palliative care and psychiatric services. An out-of-hours general practitioner service was also available to residents in the centre. Residents’ care needs were assessed on admission and thereafter using validated risk assessment tools which informed completion of care plans to direct care interventions to meet each residents’ identified needs. Care plans
were person centred, however, some care plans required review to ensure they guided staff in the delivery of safe care. For example, one resident had a diabetic care plan which did not detail how often her blood sugar levels were to be monitored or what to do should she have very low or very high blood sugar level.

An evidenced based strategy was in place to prevent falls whilst also promoting residents' independence. A physiotherapist visited the centre weekly. Daily progress notes were completed and were generally linked to care plans. The activity staff kept separate records with regard to social care engagement of residents. There was good evidence of transfer of information between the centre and acute healthcare providers. Discharge summaries for those who had spent time in acute hospitals were available in medical files reviewed. Arrangements were in place to ensure care plans were reviewed on a four-monthly basis or more often in response to changing needs and there was evidence that residents and their relatives were involved in care plan development and reviews thereafter in the files reviewed. Nutritional care plans were detailed and provided sufficient detail to direct staff as to the care to be delivered to meet the needs of the resident.

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:
The clinical nurse manager explained issues of concern are addressed immediately at local level without recourse to the formal complaints procedure. A designated individual was nominated with overall responsibility to investigate complaints. A summary of the complaints procedure was displayed prominently and was included in the statement of purpose.

A complaints policy was in place. This detailed a comprehensive process for dealing with a complaint which complied with the regulations. One complaint was being investigated at the time of this inspection. A complaints log was in place. This contained the facility to record all relevant information about complaints. The inspector reviewed the complaints log and noted that some complaints were not robustly investigated. There was poor evidence available of the satisfaction of the complaints initiator with the outcome of their complaint and there was no evidence that they were informed of the appeals process.
### Judgment:
Non Compliant - Moderate

### Outcome 17: Residents' clothing and personal property and possessions

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

### Theme:
Person-centred care and support

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

### Findings:
The inspector reviewed arrangements in place with regard to residents’ finances. The provider representative acted as an agent for two residents. Improvements were identified with the arrangements for receiving pensions to ensure the residents' monies were safeguarded and to comply with current financial regulations. The resident’s pension was being transferred to the centre's account. Deductions were then made by the provider for the residents' fees and the remaining balance was added to the resident's petty cash. No money was retained in the providers' account for any of these residents. However, the current arrangement required review as it does not afford the resident the maximum protection. He had contacted a social worker and a solicitor for advice regarding this matter and to rearrange this process.

Petty cash was kept in safe keeping for residents. Transparent arrangements were in place with regard to the documentation of all transactions, however the records were disorganised and took time to decipher. A more organised recording system would enhance clarity with regard to the petty cash. Two signatures were documented for monies in and out.

### 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:
There was an adequate complement of nursing and care staff on the day of inspection to meet the assessed needs of residents. If staff are unavailable for work and are rostered to work they are replaced by regular staff who generally work part-time. The inspector noted that the planned staff rota matched the staffing levels on duty. The supervision arrangements and skill mix of staff was appropriate. One nurse was on duty on each floor and the person in charge or clinical nurse manager were supernumerary. There is a regular pattern of rostered care staff on each work shift. There was a policy for the recruitment, selection and vetting of staff. Staff files evidenced confirmation of Garda vetting. The centre did not employ any external agency staff. All nurses employed had confirmation of their registration with the Nursing and Midwifery Board of Ireland for 2017 and all staff had up to date mandatory training.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on infection control, nutritional care, continence management dementia care.

Judgment:
Compliant
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

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<tr>
<td>Date of inspection:</td>
<td>02/10/2017</td>
</tr>
<tr>
<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:
An annual review of the quality and safety of care delivered to residents in the designated centre was not available.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

**Please state the actions you have taken or are planning to take:**
A Resident satisfaction survey will be completed at the end of November 2017. An Audit schedule will be introduced to monitor ongoing improvements in quality of care experienced by our residents. The Annual Review will then be researched for 2017.

**Proposed Timescale:** 30/04/2018

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was poor evidence available of the enactment of a quality improvement plan to address deficits identified in audits

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

**Please state the actions you have taken or are planning to take:**
Vcare electronic system to be in operation in early 2018 and will ensure a safe high quality of resident’s care. Contracts signed with HCI and CNM staff allocated to complete start up asap.

**Proposed Timescale:** 31/03/2018

**Outcome 05: Documentation to be kept at a designated centre**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some documentation was incomplete. There were gaps in the nursing progress notes and no initials or signature was available when some notes were crossed out.

In the sample of staff files reviewed there was one carer who did not have two references as required by the regulations.

**3. Action Required:**
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.
Please state the actions you have taken or are planning to take:
Two references for the carer refer to in the inspection report are now in their personnel file.
A weekly audit of all clinical documentation for three residential files / week will be carried out. Management will put in place any corrective action required identified by the audit.
A Monthly Audit Schedule will be introduced to monitor improvements in the quality of care experienced by our residents.
If required training in best practice in documentation will be provided by 31/12/2017

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:
The behaviour management plan required review to ensure that all staff was aware of the approach to take to manage the responsive behaviour, as there was not a clear reactive strategy as to how to manage to behaviour expressed.

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

Please state the actions you have taken or are planning to take:
An Audit of nursing notes will take place and management will put in place any corrective action required. An Audit schedule will be introduced to monitor on going improvements in the quality of care experienced by our Residents, if required training in best practice in documenting will be provided by 31/01/2018

Residents Care Plans will be researched to establish staff approach to Residents with Responsive Behaviour. Management will be put in place a strategy in how staff will manage Responsive Behaviour. All residents supported by bed rails or enabler will have their Care Plans reviewed, updated and where appropriate the enabling function will be discussed in detail as to why they act as an enabler rather than restraint. Management will formulate a restraint register to facilitate on going use of restraints. Where identified training will be provided.

Proposed Timescale: 28/02/2018
### Outcome 08: Health and Safety and Risk Management

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drill records did not provide a comprehensive record as to whether a full or partial evacuation had been completed, what time it took to evacuate and whether there were any impediments to safe evacuation identified.

No fire drill had been completed simulating a night duty scenario when the fewest staff were on duty.

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

**Please state the actions you have taken or are planning to take:**
Fire Training Consultant presented a fire drill simulation a night duty evacuation with night duty staff on 26th October 2017.
Fire drill records will be updated to include evacuation times and learning outcomes.

**Proposed Timescale:** 28/02/2018

### Outcome 10: Notification of Incidents

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Where incidents were deemed as requiring notification to HIQA, this was completed but not within the required timeframe.

**6. Action Required:**
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

**Please state the actions you have taken or are planning to take:**
Management have reviewed the date and nature of incidents affecting residents and have identified the reason for the delay in notification required will be adhered to in future. In future management will ensure that notification of incidents set out in paragraph 7(1)(a) to (j) of schedule 4 within 3 working days.
## 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:**
Some care plans required review to ensure they guided staff in the delivery of safe care. For example, one resident had a diabetic care plan which did not detail how often her blood sugar levels were to be monitored or what to do should she have very low or very high blood sugar level.

**7. 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:**
All Diabetic Residents Care Plans Have been reviewed and updated. Where excluded specific information containing information on Hyperglycaemia or Hypoglycaemia will be included in resident’s care plans.

### Proposed Timescale: 31/12/2017

## 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:**
Some complaints were not robustly investigated.

**8. Action Required:**
Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.

**Please state the actions you have taken or are planning to take:**
Management will update the complaints Policy taking into consideration the inspectors observation and ensure the outcome of the Residents’ complaints are discussed with the instigator.

### Proposed Timescale: 31/01/2018

### Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was poor evidence available of the satisfaction of the complaints initiator with the outcome of their complaint and there was no evidence that they were informed of the appeals process.

9. Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
Weekly management reports will quantify complaints and their outcomes. Where necessary the outcome of a complaint will be discussed with the instigator to achieve a satisfactory conclusion. The complaints policy will be explained and discussed at the next residents meeting in December 2017.

Proposed Timescale: 31/01/2018

Outcome 17: Residents' clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Financial records were reviewed for a sample of residents for whom the provider acted as a pension agent. The current arrangement required review as it does not afford the resident the maximum protection.

10. Action Required:
Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

Please state the actions you have taken or are planning to take:
It is the policy of the nursing home not to act as agent of a resident and all residents or their relatives will be advised as to how to take control of their finances. A transparent document attached to the Residents cash pouch is now in place. Any cash transaction will be signed off and witnessed by two members of staff in the presents of the Resident.

Proposed Timescale: 13/11/2017