

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Corrandulla Nursing Home
Centre ID:	OSV-0000332
Centre address:	Corrandulla, Galway.
Telephone number:	091 791 540
Email address:	corrandullanursinghome@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Hayden Healthcare Limited
Lead inspector:	Una Fitzgerald
Support inspector(s):	Brid McGoldrick; Catherine Sweeney
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	23
Number of vacancies on the date of inspection:	14

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 September 2019 17:00	10 September 2019 21:00
11 September 2019 09:30	11 September 2019 18:30

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

Outcome	Provider's self-assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non-Compliant - Major
Outcome 02: Safeguarding and Safety	Not applicable	Non-Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non-Compliant - Major
Outcome 04: Complaints procedures	Substantially Compliant	Non-Compliant - Major
Outcome 05: Suitable Staffing	Substantially Compliant	Non-Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non-Compliant - Moderate
Outcome 07: Health and Safety and Risk Management	Not applicable	Non-Compliant - Major
Outcome 08: Governance and Management	Not applicable	Non-Compliant - Major

Summary of findings from this inspection

This thematic inspection focused on the care and welfare of residents who had dementia. The inspection was unannounced and had been triggered following receipt of unsolicited information of concern received by the Office of the Chief Inspector. The concerns alleged issues relating to the capacity and capabilities of the management team that were having a direct negative impact on the quality and safety of the care delivered to resident's living in the centre. Evidence found during this inspection did substantiate these concerns.

Inspectors found that there were inadequate governance and management systems and poor oversight arrangements in place to ensure that the service provided to

residents was safe, appropriate, consistent and met regulatory requirements. There continued to be repeated regulatory non-compliances from the previous inspection dated January 2019. As a result of the level of non compliance ,representatives from Hayden Healthcare Limited were invited to a meeting with the office of Chief Inspector. Inspectors also reported on Outcome 7 Health Safety and Risk management and Outcome 8 Governance and management. An urgent action plan was issued to the provider in relation to outcome 7(regulation 28 Fire precautions).

Inspectors read the case files of a number of residents including those with dementia. A validated observation tool was used to observe practices and interactions between staff and residents within the centre. Specific focus was on residents who had dementia. Documentation such as care plans, clinical records, policies and procedures, and staff records were reviewed. There were repeated non compliances on staffing, training and development, governance and management, fire precautions, individual assessments and care plans, health care and management of responsive behaviours.

A judgment of major non-compliance was found in six of the eight outcomes inspected. These non-compliances are discussed throughout the report and the action plan at the end of the report identifies where immediate and sustained improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centers for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

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:

A previous inspection in January 2019 found significant gaps in the level of oversight and supervision of staff delivering care to the residents. Inspectors found that no improvements had been made in relation to supervision of staff. Care remained task driven and at times, inappropriate. Staff stood in front of residents while assisting them with their meals, rather than sitting next to them.

There were 23 residents accommodated on the day of inspection, six were assessed as having maximum dependency needs, five high, seven medium and five low dependency needs.

The lack of accurate assessments was of concern to inspectors as these assessments are used to inform the planning and allocation of resources. For example: the list of dependencies given to the inspectors on the day of inspection was last updated on the 26th August 2019. From the review of resident files the inspectors found clear documented evidence that this list was not accurate

The process of assessment and care planning required significant review. Inspectors reviewed a sample of residents files and noted the following gaps in a sample of 6 reviewed:

- clinical risk assessments had not been completed.
- clinical risk assessments had not been completed appropriately. For example, nutritional assessments were calculated using incorrect measurements.
- assessments were not up to date.
- risk assessments had no corresponding care plans. For example, a resident that was assessed to be at high risk of developing pressure wounds did not have a skin integrity care plan in place.
- Recommendations from allied health care professionals were not always documented into the residents care plan. For example, a resident that was reviewed by a dietitian following weight loss did not have the recommendations of the dietitian documented in the nutritional care plan or communicated to the catering team.
- Care plans were not person-centred and did not reflect the current needs of the resident

- The resuscitation status for some residents was not reviewed and signed by a clinician
- Inappropriate language and interventions were used when documenting responsive behavior assessment (ABC) charts
- Care plan interventions were not in line with best practice guidelines.
- Care plans were not reviewed and updated as required by regulations.

Residents had access to local general practitioners (GP) and an out of hours service was available. Residents had limited access to allied health professionals including speech and language therapy (SALT), occupational therapy (OT), dietetic services, chiropody, and psychiatry of later life (POLL). Inspectors reviewed the residents' records and found that recommendations made documented by the health care teams had not been reviewed, updated to care plans or communicated to appropriate staff. For example, the nurse on duty was unaware of the process of communicating recommendations from SALT to the nursing, healthcare assistants or catering teams.

A number of residents in the centre displayed symptoms of dementia including responsive behaviours. Inspectors observed inappropriate engagement between staff and resident. For example

- A resident was told to 'sit down'. The tone of voice used by the staff member was inappropriate.
- Following an altercation between two residents a staff member asked the resident 'are you five?'
- A resident had their cigarette supply restricted, without an associated risk assessment. The documentation evidenced that the resident displays agitated behaviours when they did not have access to cigarettes.

Inspectors spent time observing the dining experience in the centre. Residents were assisted with their meals in an inappropriate, unsafe and disrespectful manner. This is restated from the last inspection.

Inspectors reviewed the medication management system in the centre. A number of concerns were identified:

- some medicines were not administered in line with Nursing and Midwifery Board of Ireland (NMBI) guidelines
- prescribed doses of antibiotics had been omitted. No reason for the omission had been documented
- telephone orders were not documented in line with Nursing and Midwifery Board of Ireland (NMBI) guidelines
- the medication management policies had not been reviewed since July 2013
- oxygen and sub-cutaneous fluids had been administered to a resident without a valid prescription

Judgment:

Non-Compliant - Major

Outcome 02: Safeguarding and Safety

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:

Inspectors were not satisfied that there were sufficient measures in place to protect residents from being harmed or suffering abuse. The policy had not been reviewed since 2011. Records evidenced that not all staff in the centre had completed up-to-date training in safeguarding.

The person in charge confirmed that An Garda Síochána (police) vetting was in place for all staff. A sample of staff files reviewed confirmed this to be the case. However, inspectors were not assured that the recruitment processes in place provided the necessary reassurance that appropriate staff were appointed to work with vulnerable older persons. The provider representative had failed to complete an appropriate risk assessment in relation to the appropriateness of all staff appointments. In addition, staff had been directed to complete roles that were outside of their agreed contract of employment. This is actioned under Outcome 8 Governance and management.

There were two residents using bedrails at the time of inspection. Assessments and care plans in relation to the use of restraint were inconsistent and lacked sufficient detail. The assessments completed did not always specify what alternatives had been tried or considered and they did not include a clear clinical need for the use of the bedrail. Care plans were not always in place to guide staff in care of residents using bedrails. Inspectors were informed that bedrails are used at the insistence of family which is contrary to the national restraint policy guidelines.

Inspectors were informed on day one of the inspection that there was no resident that has responsive behaviour issues. However, this information was not accurate. Inspectors reviewed the files of a resident who did have responsive behavioural issues and found that there was no care plan in place to guide staff on how best to manage any incidents to support the resident in ensuring that they received the most appropriate care.

Inspectors followed up notifications of allegation of abuse that had been submitted to the office of the Chief Inspector since the last inspection. On review of the information inspectors judged that at the time of reporting all reasonable measures had been taken to protect the residents. However, inspectors judged that the appropriate follow up actions had not been completed in a timely manner. For example: a resident that required an independent advocacy service to assist them in financial decisions had not been made available to them in a timely manner.

There were no volunteers working within the centre.

The centre does not act as a pension agent for any resident.

Judgment:

Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation**Theme:**

Person-centred care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The inspectors had concerns that the privacy and dignity of the residents was negatively impacted due to the use of close circuit television cameras used in all of the communal areas of the centre. The inspectors were concerned that the cameras were intrusive as they were used in areas where residents and visitors would have a reasonable expectation of privacy.

As part of the inspection, the inspectors spent a period of time observing staff interactions with residents. The inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at ten minute intervals the quality of interactions between staff and residents in the communal areas. Inspectors observed that during the meal time residents were not always treated with respect. Care was observed to be delivered with minimal interaction, in a task based manner. No choice was offered to the residents. Staff stood in front of residents while assisting them with their meals, rather than sitting next to them. Residents told inspectors that they had ordered their choice of meal the day before and they had 'no idea what they had ordered'. A menu board in the dining room displayed choices for breakfast only. The radio was played at a high volume and was not conducive to a relaxed and social dining experience. Residents were not consulted in relation to what they wished to listen to.

Inspectors were not assured that residents with dementia or cognitive impairment were offered choice and range of appropriate recreational activities in line with their assessed needs. There were no activities schedule in place for residents who wished to remain in their bedrooms.

Residents committee' meetings were held infrequently. The last meeting held in April 2019 was comprehensively documented with actions identified. However, no follow up or review of the action plan was available. There was no consultation with residents who have dementia. Residents did not have timely access to an advocacy service.

Residents were facilitated to vote within the centre. Residents had access to local and national newspapers.

The routines and practices in the centre do not maximise each residents independence or choice. For example, residents were observed sitting in communal areas watching

television programmes that were not age-appropriate. Residents told inspectors that they did not want to watch the programme.

Judgment:
Non Compliant - Major

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The management team did not demonstrate the required knowledge to ensure the complaints process was implemented appropriately.

The complaints procedure was displayed in a prominent position at the entrance foyer and had been enlarged so that it can be easily read. Inspectors reviewed the detail of complaints and followed up on the unsolicited information that had been received into the office of the Chief Inspector. The complaints log template in place had appropriate sections for completion. This form captured the detail of the complaint, the complaint findings, and outlined the satisfaction level of the complainant. However, inspectors found complaints received were not always appropriately documented and investigated.

As a result of the documentation reviewed, the management of complaints was discussed at length at the feedback meeting with the management team present. Inspectors outlined that complaints management forms a part of the quality system that ensures that the service provided is safe and effective. Complaints reviewed had not been managed appropriately. There was no evidence of an effective complaints procedure. In addition, there was no learning identified. For example:

- the complaints log recorded complaints from staff on how a resident had spoken to them.
- a complaint was viewed which did not provide assurance that complaints would be investigated fully.

Judgment:
Non Compliant - Major

Outcome 05: Suitable Staffing

Theme:
Workforce

Outstanding requirement(s) from previous inspection(s):

Findings:

On the days of inspection there were 23 residents living in the centre. There were two nurses and three healthcare assistants providing direct resident care on duty between seven am to seven pm. From 19:00 hours , there was one nurse on duty. Then from 23:00 hours until 07:00 hours there was two nurses on duty. There was a full- time person in charge who was supported in her role by the clinical nurse manager (CNM). In light of the non compliances found under regulation 28 fire precautions a review of staffing provided on night duty was required.

A number of staff files were reviewed on the day of inspection. All files contained the information required as per Schedule 2 of the regulations. There was an induction programme for newly-recruited staff and records of induction training were maintained on staff files. Garda vetting was in place for all staff files reviewed. Inspectors reviewed the training records and found gaps in mandatory training required by the regulations. This included training in moving and handling and safeguarding vulnerable persons. Certificates of training were not kept in staff files but were made available on request.

Inspectors were not assured that staff were appropriately supervised. This is a restated non compliance since the last inspection. This was evidenced by:

- Nursing handover report observed by the inspectors did not have insufficient detail given. For example: a family discussion had occurred with one resident on their resuscitation status. This information was not communicated between the day and night time staff.
- Nursing staff required further training and supervision in relation to care planning and assessment as evidenced by the gaps noted in nursing documentation.
- Inspectors observed multiple resident and staff interactions that were disrespectful and inappropriate. For example: inspectors observed a member of staff assisting a resident with their meal. The resident was lying on their side facing the opposite direction. The resident could not see the person who was feeding them. The only conversation heard by the inspector was the direction "open your mouth".
- Unsafe practice in how the care team were assisting residents with feeding. This is a repeated non compliance
- Care delivered was task driven and not person centred. This is a repeated non compliance
- The person in charge had directed a member of staff employed in non clinical duties to deliver direct care to residents without firstly ensuring that they had the training and competency required to be involved in care delivery.

Copies of the Health Act, regulations and standards were not readily available to all staff. Supervision and mentoring was required to bring the centre into compliance with regulations and to improve the quality and safety of the care delivered to residents living in the centre.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises**Theme:**

Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The centre is located in the village of Corrandulla and is approximately 18 kilometres from Galway city. The centre is organised into two units over two floors and there was a lift and two stairways to access the upper floor. Bedroom accommodation consists of 26 single rooms, four double rooms and one room that can accommodate three residents. On the day of inspection there were no residents sharing a bedroom. The centre was generally well maintained. All areas were visibly clean. Equipment and appliances such as hoists, wheelchairs and walking aids were available to support and promote the independence of residents.

There was sufficient lighting and contrast in the colours used for floors, walls and handrails. However, there was poor directional signage in some areas to assist residents locate varied facilities and exits. There is a long corridor that links the two units. This corridor is narrow and clinical in presentation. For example: limited paintings/pictures on the walls, there was no seating should a resident need to rest.

There were several areas where residents could sit during the day. There were fireplaces in sitting rooms that added visual impact and provided a focal point for residents. The first floor is primarily bedrooms. There is a snug room for resident use. However, this room was locked throughout the two days and not available for any resident to use. The dining room in the main unit was large enough to accommodate the number of residents present on the day of inspection. Communal bathrooms and toilets were identifiable by a sign with a word and a picture.

The person in charge confirmed that the centre does not have a dementia specific unit. The unit at the back of the premises mostly accommodated residents who had dementia as it was smaller in size. The bedrooms, sitting room and dining room are all located in close proximity giving the unit a more homely feeling.

Residents' bedrooms are located on the ground and first floor. Inspectors visited multiple resident bedrooms. There was adequate space for the storage of personal belongings. Inspectors did not see any clocks or calendars that would assist in keeping residents with dementia orientated to time. Residents were encouraged to personalise their rooms and some had photographs and other personal belongings in their

bedrooms. Some bedrooms had a picture of the resident who accommodated that room on the door, the aim of these were to provide visual cues for people to recognise their own bedroom.

Residents had access to a small secure enclosed paved courtyard area. This door was unlocked and residents could easily access the area independently. Residents who smoked had open access to a smoking room that was part of the enclosed courtyard. The smoking room was maintained in an unclean, unkept condition and required thorough cleaning. The hard seating provided was worn. Records evidenced that a resident who had brought out a comfortable cushion to this area had been instructed by staff that this practice was not permitted. When the resident had questioned the staff member the resident had been told that the smoking room was not for socialising. This instruction is inappropriate and is a violation of a residents right of choice.

Residents had access to equipment that promoted their independence and comfort. There was an appropriate level of assistive equipment, such as specialist chairs, wheelchairs, walking aids, hoists, pressure relieving cushions and beds to meet residents' needs.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

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:

Improvements were required to risk management to ensure that all risks were identified, assessed and measures put in place to control the risks identified.

Inspectors found that there were insufficient processes in place in the centre to ensure adequate arrangements were in place against the risk of fire. Inspectors were not assured that the larger compartments within the centre can be evacuated in a timely manner with the staff and equipment resources available. This was evidenced by:

- The fire floor plans were confusing and were difficult to decipher the nearest exit route. There was no indication on plans of the location of fire equipment that may be required for evacuation.
- There was one exit from the church. It was unclear if the boundary walls and ceiling /roof space were fire rated. The balcony in the church was used for storage of papers, mattress and bedrails. Resident bedrooms are located in this zone.

- The fire exit from the unit had moss and no hand rails to support residents to a safe place should evacuation be required.
- Staff spoken with during the inspection displayed poor knowledge on fire evacuation procedures
- There was no documentary evidence of simulated fire drills reflecting night time conditions and from the compartment with the largest number of residents. The most recent drill 01/07/2019 recorded an 8 min delay in finding the location of the fire, the evacuation of one resident and the total drill time recorded was 11 mins.
- There are two fire panels which were not connected. This posed a potential risk for a delay in the response time.
- Personal Emergency Evacuation Plans reviewed were not always accurate and were not updated to reflect a change in residents evacuation needs.

The fire policy was dated 2016 and information contained in the policy did not align with fire instructions displayed in the centre.

Adequate arrangements had not been made for reviewing fire precautions.

- Learning outcomes or recommendations for future learning or training were not recorded on fire drill reports thereby reducing the opportunity to maximise learning from drills and the review of fire precautions.

Adequate arrangements had not been made for giving warning of fires.

- It was noted that the fire detection and alarm system did not provide a fully addressable system with coverage throughout the centre.

As a result of the findings on regulation 28 Fire precautions the provider was issued with an urgent action plan on what immediate actions would be taken to bring the centre into compliance with the regulations.

Inspectors observed that the centre was clean. Following the last inspection additional hours had been allocated to the cleaning roster. Staff had received training. The procedures in place for managing the prevention and control of infection had been improved and were in line with National Standards. Staff spoken with were knowledgeable on the cloth colour coded system in place. All areas of the centre including resident's bedrooms were cleaned daily. There were hand hygiene alcohol dispensers strategically placed along all corridors.

The centre has a risk management policy. Inspectors reviewed the operational risk register and found that overall the management has not identified the risks that were found on the day of inspection. For example:

- Inspectors noted that the enclosed courtyard was full of pebble stones that were a falls risk to residents.
- The requirement for supervision of residents with swallowing difficulty at meal times
- The recruitment of sufficient staff with the appropriate training to work in direct provision of care
- The location of storage units with gloves and aprons which posed a risk of choking for residents with dementia.

Judgment:

Non Compliant - Major

Outcome 08: Governance and Management**Theme:**

Governance, Leadership and Management

Outstanding requirement(s) from previous inspection(s):

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

Findings:

Governance and leadership arrangements required significant attention to ensure that management systems in place effectively monitored the totality of the service to ensure it was safe, appropriate, consistent and met regulatory requirements. Hayden Healthcare limited was not providing a safe service. There continued to be repeated regulatory non-compliances from the previous inspection dated January 2019. The centre has been moving away from compliance as evidenced by non-compliances identified on this inspection. This inspection was a triggered inspection following receipt of unsolicited information of concern. A judgment of major non compliance was informed by cumulative findings.

This is evidenced by:

- Failure to ensure that complaints were appropriately recorded and managed.
- Failure to ensure that inconsistencies in nursing documentation, care planning and assessments were addressed since the last inspection.
- Failure to ensure that advice received from allied health-care professionals was followed up in a timely manner to ensure a positive outcome for residents. For example: timely commencement of antibiotics.
- Failure to ensure compliance with fire regulations and inadequate oversight of fire safety management. Staff had poor knowledge of procedures for evacuation of residents.
- Failure to ensure compliance with the national policy on the use of restraint. For example, bedrails were in place at the insistence of family and not based on a clinical assessment of need.
- Failure to ensure and uphold residents rights' to privacy and dignity, For example: the use of CCTV in communal rooms.
- Failure to ensure that staff were appropriately trained in mandatory regulation requirements.
- Failure to ensure that staff were suitably qualified and appointed into roles that aligned with their contract of employment.
- Failure to ensure that staff were appropriately supervised. For example, the continued and unsafe practices observed by inspectors when staff are assisting residents with their meals.

Systems in place to review and monitor the quality and safety of care required review to ensure that improvements are brought about in work practices and to achieve optimal outcomes for residents. Recent audits had been completed. Findings were set out but there was no evidence of action plans in place to address areas for improvement. Finding on this inspection evidenced that the lines of authority and responsibility within the centre was not clear. For example, the complaints log evidenced that the maintenance staff had been requested by the nurse in charge to assist in the management of a complaint.

Judgment:
Non Compliant - Major

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:

Una Fitzgerald
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Corrandulla Nursing Home
Centre ID:	OSV-0000332
Date of inspection:	10/09/2019
Date of response:	11/10/2019

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

Some clinical risk assessments had not been completed

1. 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:

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

Resident clinical risk assessments will be reviewed updated and completed

Proposed Timescale: 29/11/2019

Theme:

Safe care and support

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

A number of clinical risk assessments had not been completed appropriately. For example, nutritional assessments were calculated using incorrect measurements. Some assessments were not up to date.

2. Action Required:

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

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

Resident clinical risk assessments will be reviewed updated and completed

Proposed Timescale: 29/11/2019

Theme:

Safe care and support

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

Care plans were not person-centred and did not reflect the current needs of the resident

3. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Care plans to be reviewed and updated accordingly.

Proposed Timescale: 27/12/2019

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Care plans were not reviewed and updated as required by regulations.

4. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Care plans to be reviewed and updated accordingly.

Proposed Timescale: 27/12/2019

Theme:

Safe care and support

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

Care plan interventions were not in line with best practice guidelines

5. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

Care plans to be reviewed and updated accordingly.

Proposed Timescale: 27/12/2019

Theme:

Safe care and support

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

Recommendations documented by the health care teams had not been reviewed, updated to care plans or communicated to appropriate staff.

6. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

Communication to staff regarding AHP to be communicated through handovers daily – immediate.

Care plans to be reviewed and updated accordingly.

Proposed Timescale: 27/12/2019

Theme:

Safe care and support

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

Some medicines were not administered in line with Nursing and Midwifery Board of Ireland (NMBI) guidelines. Oxygen and sub-cutaneous fluids had been administered to a resident without a valid prescription

7. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

All prescriptions to be reviewed and signed by the Gp. Full 3rd quarterly medication review requested of GP and pharmacist.

Proposed Timescale: 31/10/2019

Outcome 02: Safeguarding and Safety**Theme:**

Safe care and support

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

Assessments and care plans in relation to the use of restraint were inconsistent and

lacked sufficient detail. The assessments completed did not always specify what alternatives had been tried or considered and they did not include a clear clinical need for the use of the bedrail. Evidence was received that bedrails are used at the insistence of family which is contrary to the national restraint policy guidelines.

8. 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:

All restraint assessments will be fully completed in line with policy guidelines.

Proposed Timescale: 18/10/2019

Theme:

Safe care and support

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

Staff were not clear in relation to residents needs in relation to responsive behaviours. The file of a resident who did have responsive behavioural issues had no care plan in place to guide staff on how best to manage any incidents to support the resident in ensuring that they received the most appropriate care.

9. Action Required:

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

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

All staff compete training and care plan to be completed.

Proposed Timescale: 25/10/2019

Theme:

Safe care and support

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

Records evidenced that not all staff in the centre had completed up-to-date training in safeguarding.

10. 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 who are currently employed to have up to date training completed by 25/10/2019

Proposed Timescale: 25/10/2019

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

There were no activities schedule in place for residents who wished to remain in their bedrooms.

11. 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:

A planned activity schedule will be put in place in accordance with the residents wishes.

Proposed Timescale: 29/10/2019

Theme:

Person-centred care and support

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

Residents with dementia or cognitive impairment were not offered a choice and range of appropriate recreational activities in line with their assessed needs.

12. 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:

A planned activity schedule will be put in place in accordance with the residents wishes and needs.

Proposed Timescale: 01/11/2019

Theme:

Person-centred care and support

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

The routines and practices in the centre do not maximise each residents independence or choice

13. 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 inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

Supervision, working with and training of staff to ensure residents are exercising their choice and rights.

Proposed Timescale: 30/12/2019

Theme:

Person-centred care and support

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

Residents did not have timely access to an advocacy service.

14. Action Required:

Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

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

Referrals for advocates will be made as required or requested by residents. Current referrals will be followed up.

Proposed Timescale: 11/11/2019

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

Complaints reviewed had not been effectively responded to.

15. 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 inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

Currently in place, we will try to engage further with those who refuse or do not wish to engage with the complaints process.

Proposed Timescale: 21/10/2019

Theme:

Person-centred care and support

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

The management team did not demonstrate the required knowledge to ensure the complaints process was implemented appropriately.

16. Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

All training current and updated by management, we will try to engage further with those who refuse or do not wish to engage with the complaints process. From this point on All residents' complaints will be duplicated in there file with care plans created / updated as necessary

Proposed Timescale: 21/10/2019

Outcome 05: Suitable Staffing

Theme:

Workforce

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

A review of staffing was required to ensure that there were sufficient staffing available to evacuate residents in the event of a fire.

17. 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:

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

Staffing levels increased by 50% and will continue

Proposed Timescale: 24/09/2019

Theme:

Workforce

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

There were gaps in mandatory training required by the regulations. This included training moving and handling and safeguarding vulnerable persons.

18. 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 inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

All staff have their mandatory training up to date.

Proposed Timescale: 11/10/2019

Theme:

Workforce

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

Staff were not appropriately supervised. This is a restated non compliance since the last inspection.

19. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Increase in staffing supervision, including working with, training and accessing/audits to ensure appropriate care and interactions.

Staff nurse meeting and general staff meetings held quarterly

Proposed Timescale: 30/12/2019

Theme:

Workforce

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

Copies of the Health Act, regulations and standards were not readily available to all staff.

20. Action Required:

Under Regulation 16(2)(b) you are required to: Make copies available to staff of any relevant standards set and published 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:

Health act and regulations are kept with all policies and procedures – have now been made more prominent and all staff made aware where they are kept.

Proposed Timescale: 11/10/2019

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

A communal room was locked throughout the two days and not available for any resident to use.

The smoking room was maintained in an unclean, unkept condition and required thorough cleaning. The hard seating provided was worn.

21. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

The snug is now open and staff have been reminded that this area is not to be closed. Smoking area, cleaned nightly, seating fire rated, previously approved and not worn. Frame of conservatory to be cleaned.

Proposed Timescale: 04/11/2019

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

Fire floor plans were confusing and were difficult to decipher the nearest exit route. There was no indication on fire floor plans the location of fire equipment that may be required for evacuation. The fire exit from the unit had moss and no hand rails which would delay in providing escape in an emergency or fire evacuation.

22. Action Required:

Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

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

In process of being updated awaiting fire engineer approval.

Proposed Timescale: 31/10/2019

Theme:

Safe care and support

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

There is one exit from the church. Some bedrooms are located in this zone. Flammable items were being stored in areas where there were concerns about the fabric of the building.

23. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Balcony has been cleared completely. Fire engineer contracted to assess building.

Proposed Timescale: 28/10/2019

Theme:

Safe care and support

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

Staff displayed poor knowledge on fire evacuation procedures.

24. 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:

Fire Training updated. Policy and Procedures reviewed. Drill techniques updated and Drills at night level staffing in progress.

Proposed Timescale: 18/11/2019

Theme:

Safe care and support

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

Fire drills were not being completed in a way that provided assurance to the provider that arrangements were in place to ensure adequate means of escape was being provided.

25. 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 updated. Policy and Procedures reviewed. Drill techniques updated and Drills at night level staffing in progress.

Proposed Timescale: 18/11/2019

Theme:

Safe care and support

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

There are two fire panels which were not connected. This posed a potential risk for a delay in the response time. The systems (both panels) are not an L1 addressable System.

26. Action Required:

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

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

L1 system currently out to tender and awaiting Fire Engineer recommendations prior to work commencement. Communications systems and staffing increased with improved fire drills undertaken. Risk assessments updated. Signage upgraded.

Proposed Timescale: 21/10/2019

Theme:

Safe care and support

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

Personal Emergency Evacuation Plans reviewed were not always accurate and were not updated to reflect a change in residents evacuation needs.

27. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

All PEEPs reviewed. Reviewed by Fire Engineer. No changes. Reviewed to continue to be conducted annually and at each health/dependency change.

Proposed Timescale: 09/10/2019

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

The Management systems in place were not adequate to ensure the centre was being operated in line with the regulations, and to ensure residents needs were being met.

28. Action Required:

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

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

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

Training updated, supervision, assessments, audits, care-plans to be updated and improved.

Proposed Timescale: 30/12/2019

Theme:

Governance, Leadership and Management

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

The lines of authority and responsibility within the centre was not clear.

29. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

The inspector has reviewed the provider compliance plan. The actions proposed to address the regulatory non-compliance does not adequately assure the Chief inspector that the actions will result in compliance with the regulations.

Staff reminded of organisational reporting structure. Organisational chart reviewed and confirmed as accurate. Job descriptions reviewed. All staff received a copy of their job description. Re-issuing copies to staff as a reminder. Staff meeting reinforcement.

Proposed Timescale: 13/12/2019