Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Maria Goretti Nursing Home
Centre ID:	OSV-0000417
Centre address:	Proonts, Kilmallock, Limerick.
Telephone number:	063 989 83
Email address:	admin@mgnh.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Maria Goretti NH Partnership
Provider Nominee:	
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	53
Number of vacancies on the date of inspection:	8

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 to monitor compliance with specific outcomes as part of a thematic inspection. 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:
20 May 2019 10:00	20 May 2019 18:30
21 May 2019 08:30	21 May 2019 16:30

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	Compliance demonstrated	Substantially Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 08: Governance and Management		Non Compliant - Major

Summary of findings from this inspection

This thematic inspection focused on the care and welfare of residents who had dementia. As part of the thematic inspection process, providers were invited to attend information seminars given by the Office of the Chief Inspector. In addition, evidence-based guidance was developed to guide best practice in dementia care and to inform the inspection process. Prior to the inspection, a provider self-assessment document had been completed and the service was assessed against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential

Care Settings for Older People in Ireland.

While the inspection predominantly focused on the experience of residents with dementia, when other issues requiring attention were identified during the inspection process, these were also addressed. The inspector was particularly concerned about governance and management arrangements in the centre and the impact of this on staff supervision and care delivery.

Maria Goretti Nursing Home is located in a rural area of Co. Limerick, approximately 1.5 kilometres from the town of Kilmallock. It is a single storey premises that is registered to accommodate 61 residents in 21 single bedrooms, nine twin bedrooms and five four-bedded rooms. There are also two apartments and each one consists of a single bedroom, sitting room and small kitchen. All of the bedrooms were en suite with toilet, shower and wash hand basin. There were 53 residents living in the centre on the days of the inspection.

The centre has an enclosed garden that is readily accessible to residents. The garden is landscaped to a high standard with raised flower beds, a large water feature, garden furniture and lots of potted plants that were chosen by residents. Some residents were involved in maintaining the garden.

The inspector tracked the care pathways of residents with dementia and spent three periods of time observing how staff related to residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents. The observations took place in the main sitting room where most residents spent their day when not in their bedrooms. The inspector observed that staff interactions were person-centred, meaningful and were not rushed. Residents were observed to be treated with dignity and respect during all staff contacts.

Residents were provided with choice over how to spend their day. Residents were seen to come and have their breakfast throughout the morning. Discussions with residents confirmed that they could choose when to get up in the morning and when to go to bed. There was a programme of activities facilitated by activity coordinators. While there was a broad range of activities provided, these were predominantly held in the afternoon. The inspector observed that in the morning time, there were minimal organised activities and residents were observed in the sitting room, with only minimal stimulation.

Each resident had a pre-admission assessment completed in order to ensure the service could meet their needs and to plan care. The health needs of residents were met to a good standard. There was good access to medical care and to allied health services such as physiotherapy, dietetics, speech and language therapy. Care plans were generally good and provide person-centred guidance on care to be delivered to residents. Eleven of the 53 residents living in the centre on the days of the inspection had a diagnosis of dementia and a further four residents had a cognitive impairment.

Choice of food was offered to residents and food appeared to be nutritious and available in sufficient quantities. Residents requiring assistance at meal times were

assisted by staff in a respectful manner. Staff were seen to interact with residents throughout the meal and appeared to hold meaningful conversations on topics that were of interest to residents. While the dining experience was observed to be positive for a large number of residents, the experience could be enhanced for others. A number of residents, predominantly residents requiring assistance with their meals, had their meals in the sitting room. Therefore, these residents spent most of their day in the one room. This practice also meant that meal times did not provide for the level of social interaction possible, when residents had their meals at a dining room table with other residents.

Overall, governance and management arrangements were inadequate and did not provide for the safe and effective delivery of care. The person in charge had recently resigned and the provider was in the process of appointing a new person in charge. From discussions with staff and a review of records, it was evident that there was not a unity of purpose within the senior management team. Discord among senior managers was negatively impacting on the day-to-day operation of the centre. Where there were issues identified in relation to staff performance, this was not addressed in accordance with the reporting relationships set out in the Statement of Purpose. Additionally, senior management had not reached a consensus in relation to which, if any, staff members were not performing optimally. There was also a significant degree of disharmony among a small number of staff and this was impacting negatively on some residents.

Other issues identified during the inspection related to the management of risk and fire safety. The inspector observed that an emergency exit was partially obstructed by a mattress on the first day of the inspection, and while this was removed, the inspector observed that the mattress was again found to be in the same location on the second day of the inspection. Doors to areas that may contain items of risk to residents, such as the laundry room and the staff room, were left unlocked.

The Action Plan at the end of this report identifies the areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3. The inspector focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia.

Of the fifty three residents in the centre on the days of the inspection, eleven had a formal diagnosis of dementia and four residents had a cognitive impairment but did not have a confirmed diagnosis of dementia.

Residents were predominantly admitted from acute hospitals but were also admitted directly from their home. The person in charge usually assessed prospective residents with dementia prior to admission. Prospective residents and their families were welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. This gave residents and their families information about the centre and also assured them that the service could adequately meet their needs.

Residents had access to general practitioners (GPs) of their choice. Medical notes indicated that residents were reviewed regularly by their respective GPs. Residents with dementia were supported to attend out-patient appointments and were referred as necessary for care in the acute hospital services. There were records available showing that information was shared between the centre when residents were transferred to hospital or discharged to the centre.

There was good access to allied health services. A community psychiatric nurse visited the centre regularly to monitor progress of residents referred to the team. Dietetic, speech and language and wound care services were provided by a private nutritional supply company and there was good access. Systems were in place for residents to have regular reviews by dental and optical services. Systems had yet to be established to ensure that residents that qualified for national screening programmes were facilitated to participate in the programme, should they so wish.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as the risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed based on these assessments. A sample of care plans reviewed contained the required information to guide care delivery. Overall, care plans were person-centred and were updated regularly to reflect changing care needs. The inspector found that staff knew residents well and were knowledgeable regarding residents' likes, dislikes and their individual needs. The inspector viewed a sample of residents' records, some of whom had been transferred to hospital from the centre, and found that appropriate information about their health, medications and their specific communication needs were shared with the admitting hospital. Records of residents' assessments reviewed included comprehensive biographical details, medical history, and nursing assessments.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services, as required. There were no residents at active end-of-life stage on the days of the inspection. There was evidence of preliminary discussions with residents around preferences for end of life care. A pain assessment tool suitable for residents who were unable to verbalize their levels of pain was available. Residents' relatives were facilitated to stay overnight with them when they became very ill. Religious and cultural needs were facilitated. Members of the local clergy provided pastoral and spiritual support to residents as they wished. There was a weekly mass in the centre. The centre also had a small oratory for use by residents to pray of for periods of reflection.

The nutrition and hydration needs of residents with dementia were assessed and monitored. A policy document was in place to inform best practice, including use of a validated assessment tool to screen residents for nutritional risk on admission and regularly thereafter. Residents' weights were checked routinely on a monthly basis and more frequently, if they experienced unintentional weight loss. Nutritional assessments and care plans were in place that outlined the recommendations of the dietican and speech and language therapists, where appropriate.

There were adequate arrangements in place for communication between nursing and catering staff to support residents with special dietary requirements. A discussion with catering staff indicated that they had a personal knowledge of individual residents likes, dislikes and prescribed diets. Catering staff made efforts to ensure residents were provided with food that met their individual preferences and needs. Residents were provided with snacks throughout the day. The inspector saw that residents had a choice of hot meals for lunch and tea. Residents on weight-reducing, diabetic, fortified and modified consistency diets received the correct diets. Thickened fluids were provided for residents at the consistency prescribed by the speech and language therapist. Alternatives to the menu on offer were available to residents. The mealtime experience is discussed in more detail under Outcome 3.

There was a centre-specific medication policy with procedures for safe ordering, prescribing, storing and administration of medicines. All residents had photographic identification in place. Medications in the centre were supplied in a monitored dosage system. There was a system of reconciliation to ensure that what was delivered matched

the prescription.

The supply and administration of scheduled controlled drugs was checked and was correct against the drug register, in line with legislation. Two nurses checked the quantity of these medications at the start of each shift. The nurse, spoken with by the inspector, displayed a good knowledge of the requirements in the area of controlled drugs and the responsibilities of the registered nurse to maintain careful records.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

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 safeguard and protect residents with dementia from abuse. There was a policy and procedure in place to inform the prevention, detection and response to any allegations, disclosures or incidents of abuse in the centre. Systems were in place to ensure that allegations of abuse were fully investigated, and that residents were safeguarded during the investigation process. Where there were allegations of abuse, a safeguarding plan was developed while the investigation was underway. Staff spoken with on the days of this inspection could describe how they would identify and respond to allegations of abuse. Residents told the inspector that they felt safe in the centre and spoke positively about the staff caring for them. All interactions by staff with residents observed by the inspector were kind and respectful.

There was a policy and procedure in place for the management of responsive behaviour. The inspector was told that a small number of residents with dementia were predisposed to experiencing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were familiar with triggers to resident's behaviours and were observed using the most appropriate person centred interventions to de-escalate behaviours. There were behavioural support plans in place for residents that exhibited responsive behaviour and these provide adequate detail on the behaviours and ways of preventing escalation.

A policy to inform management of restraint was available and reflected procedural guidelines in line with the national restraint policy. Improvements were noted in the use of restraint and the restraint register listed nine residents with bedrails in place and two residents had lap belts for postural support. Safety checks were carried out for residents when bedrails were in place.

There were systems in place for the management of residents' finances. The inspector was informed that the provider was pension agent for eight residents. The procedures in place for managing finances were reviewed and the inspector found that satisfactory records were maintained.

Judgment:
Compliant

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:
Residents confirmed that their religious rights were supported. The preferences of all religious denominations were respected and facilitated. Religious ceremonies were celebrated in the centre that included a weekly mass for Catholic residents.

Staff were knowledgeable of individual resident's needs and preferences, addressed residents by their name and conversed with them on issues that appeared to be of interest or relevant to the resident. The inspector observed staff interacting with residents in an appropriate and respectful manner. The inspector observed staff respecting residents privacy, including knocking on bedroom doors before entering.

The inspector observed residents coming to the dining room throughout the morning for their breakfast and residents confirmed that they could get up in the morning at a time of their choosing and go to bed whenever they wished. Residents confirmed that they could choose what they liked to wear and the inspector saw residents looking well dressed.

Residents had previously been facilitated to vote in local and national elections and the returning officer visited the centre with the ballot box. However, for the forthcoming European and local elections, residents who were registered to vote received polling cards stating that their designated polling station was in the local school. This meant that the returning officer would not be visiting the centre and if residents wished to vote, they would have to leave the centre. The person in charge stated that they would support those residents who wished to vote to attend the local polling station, however, this would not be practical for a number of residents.

Residents were consulted about how the centre is planned and run through both residents and relatives' meetings. Residents' meetings were held approximately every two months and family forums were held approximately every six months. There was a

standing agenda for the residents' meetings that included compliments, complaints, advocacy, hygiene, activities and mealtimes. Records of residents meetings could be enhanced by the inclusion of actions from the previous meeting, clearly indicating whether or not issues raised at these meetings were addressed to the satisfaction of residents.

Information on residents' interests were contained in documents such as ''A Key to Me''. Activities were facilitated by two activity coordinators in addition to some external providers. The programme of activities included flower arranging, baking, arts and crafts, and bingo. An art therapist visited for one day each week and there was also pet therapy on a weekly basis. While residents were observed to be enthusiastically participating in activities, predominantly in the afternoon, residents were left with limited stimulation in the morning times. On both days of the inspection residents were seen in the sitting room with the television on, but none of the residents showed any interest in what was on television.

The inspector spent three periods of time observing staff interactions with residents. A validated observational tool, the quality of interactions schedule (QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents in the communal sitting areas on both floors. The inspector observed that staff knew residents well and engaged with them in a personal meaningful way by asking about their wellbeing. Residents told the inspector that they had good relationships with staff and found them very helpful.

Residents had their meals in two dining rooms, in a sitting room and some residents had their meals in their bedrooms. One of the dining rooms was predominantly used by residents who required minimal supervision. Meal times here were observed to be social occasions and residents were seen to interact with each other throughout the meal. The second dining room was adjacent to the kitchen and was used predominantly by residents who required a higher level of supervision. A number of residents had their meals in the sitting room and some of these residents had their meals from bed side tables. Because of this, these residents spent most of their day in the one room and mealtimes were not optimised to enhance the variety of each resident's day.

Judgment:
Non Compliant - Moderate

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:

A written complaints policy was available in the centre and the inspector saw that the complaints procedure was on display in a prominent place. There was a nominated person to deal with complaints in the centre. The complaints procedure included an independent appeals process.

The inspector reviewed the complaints log and found the complaints process was in place to ensure the complaints of residents, their families or next of kin, including those with dementia, were listened to and acted upon. Residents and relatives confirmed that there were no barriers to reporting complaints to any member of staff.

There was evidence that the person in charge monitored complaints or any issues raised by being readily available and regularly speaking to residents, visitors and staff. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded, as required by the regulations.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspector observed staff providing care in a respectful manner. Residents appeared to be familiar with staff.

An actual and planned roster was maintained in the centre, with any changes clearly indicated. There was a regular pattern of rostered care staff. Based on a review of the roster and the observations of the inspector, there were adequate numbers and skill mix of staff to meet the needs of the residents living in the centre on the days of the inspection.

Some improvements were required in relation to the recruitment, induction, supervision and training of staff. A review of staff files indicated that most of the requirements of Schedule 2 of the regulations were met. Of the sample of staff files reviewed, all had evidence of identity and a full employment history that included an explanation for any gaps. All staff had Garda vetting completed prior to commencing employment. However, references were not obtained from one staff member's most recent employer prior to commencing employment. Evidence of current professional registration for registered nurses was seen by the inspector.

While there was an induction process in place for new staff, the induction record

indicating that the staff member had satisfactorily completed the induction process was not available for all staff. In instances where it was indicated that staff required an extended period of induction, the inspector was assured that staff had successfully completed the induction process, however, there was no record demonstrating how management were assured of staff competence to perform the role for which they were employed.

Significant improvements were required in relation to staff supervision and this is further addressed under Governance and Management in this report. Management arrangements were not effective in adequately supervising staff to ensure that performance was at the required standard or in addressing issues of performance brought to their attention.

A review of training records indicated that staff were facilitated to attend training. However, not all staff had attended up-to-date training in mandatory areas such as fire safety, manual and people handling, safeguarding residents from abuse, or responsive behaviour.

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:
Maria Goretti nursing home is located in a rural area of Co. Limerick, approximately 1.5 kilometres from the town of Kilmallock. It is a single storey premises that is registered to accommodate 61 residents in 21 single bedrooms, nine twin bedrooms and five four-bedded rooms. There are also two apartments and each one consists of a single bedroom, sitting room and small kitchen. All of the bedrooms were en suite with toilet, shower and wash hand basin. There were 53 residents living in the centre on the days of the inspection.

On the days of inspection the centre was bright, clean and in a good state of repair. Communal space comprised two sitting rooms, a visitors/family room and two dining rooms. There was a small oratory. There was also a smoking room that was ventilated to the external air by natural and mechanical means. There was a fire blanket and fire extinguisher located outside the smoking room.

There is an enclosed garden that was landscaped to a high standard. The garden is readily accessible to residents and is decorated with raised flower beds, a large water

feature, garden furniture and lots of potted plants that were chosen by residents. Some residents were involved in maintaining the garden and were supported by staff to do so.

Efforts had been made to use memorabilia to enhance the décor of the centre and to provide a stimulating environment for residents. There were a number of antiques located throughout the centre to give it a more homely feel. These included an old style dresser; a wash stand, jug and basin; and a radio. An old style shop front had also been created in one of the sitting rooms. There was adequate signage in place to support residents navigate the centre.

Records were available demonstrating the preventive maintenance of equipment such as beds, hoists and speciality mattresses.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

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

Findings:
A number of issues were identified by the inspector that required improvement in relation to risk management, fire safety and infection prevention and control.

In relation to the management of risk, doors to areas that could potentially pose a risk to residents were not locked, such as the staff room and the laundry. A review was required of recently installed emergency exits in the context of their accessibility to residents that may be at risk of leaving the premises without alerting staff.

Significant work had been undertaken on fire safety in the centre since the previous inspection, particularly in relation to reducing the size of a fire compartment and the installation of additional fire exits. All of the actions identified on that inspection had been addressed. Some additional operational issues were identified on this inspection. The inspector noted that a mattress was stored on a corridor, close to an emergency exit and could cause an obstruction in the event of an emergency evacuation. While this was brought to the attention of the person in charge on the first day of the inspection, the inspector found that the mattress was again placed in this location on the second day of the inspection. It was also observed that some fire doors were held open with chairs, which would prevent them for operating effectively in the event of a fire. Oxygen cylinders were stored in the nurses' office proximal to combustible material. Maps used to guide residents and others to the nearest emergency exit required review in relation to identifying your location in the centre in the context of the closest emergency exit.

The maps did not identify all cross corridor fire doors and the orientation of the map could be improved in relation to the direction you need to travel to get to the closest area of relative safety.

One sluice room was extremely cluttered as it was used for storing various waste bins making the wash hand basin inaccessible. In addition to obstructing the wash hand basin, the sluice rooms was an inappropriate to store such equipment.

Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
Overall, significant improvements were required in relation to governance and management. While there was a clearly defined management structure outlined in the Statement of Purpose, this was not always adhered to in the day-to-day operation of the centre.

A review of records identified, that at times, there was a significant degree of staff disharmony among a small number of staff. Where staff members had expressed concern in relation to the performance of other staff, these were not always addressed through the governance arrangements outlined in the statement of purpose. Various members of the senior management team became involved in performance management related issues without a unity of purpose. This contributed significantly to staff disharmony and also impacted on staff performance. Due to discord within the senior management team, agreement was not reached in relation to specifically which members of staff, if any, were not performing to the required standard. As a result, issues in relation to staff performance were not satisfactorily addressed. This had an impact on the day-to-day lives of residents living in the centre and was communicated to the inspector in discussions with residents.

Deficits in governance and management arrangements were also supported by a review of the complaints log. It was noted that there were a number of complaints from relatives in relation to the level of personal care provided to residents. While each of these was addressed on an individual basis, a theme extracted by the inspector from a review of complaints was that personal care was a recurring topic of complaint.

The person in charge had recently resigned and management were in the process of appointing a new person in charge. The provider was reminded of the requirements of

the regulations in relation to the appointment of a new person in charge.
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:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Maria Goretti Nursing Home
Centre ID:	OSV-0000417
Date of inspection:	20/05/2019
Date of response:	04/07/2019

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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Systems had yet to be established to ensure that residents that qualified for national screening programmes were facilitated to participate in the programme, should they so wish.

1. Action Required:
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a

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

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:
Reviewed all residents in respect of above and have highlighted those who are eligible for the National Screening Programmes.

The National Screening programme was explained to each resident and consent was obtained.

Arrangements were made for their participation if they so wished in the programme including GP arranging registration for residents on the relevant screening.

1 resident only is eligible for screening under Breast Check and has received an appointment for mobile breast check unit in July.
None eligible for Cervical Check.
2 residents are eligible for bowel screening and both screening test have been completed and returned to screening programme.
7 residents are eligible for Diabetic Retina Screening. All have been registered and awaiting appointments for same.

It would be hoped that all applications for screening as applicable will be completed by the end of the year.

Proposed Timescale: 31/12/2019

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:
For the forthcoming European and local elections, residents that were registered to vote received polling cards stating that their designated polling station was in the local school. This meant that the returning officer would not be visiting the centre and if residents wished to vote, they would have to leave the centre. The person in charge stated that they would support those residents that wished to vote to attend the local polling station, however, this would not be practical for a number of residents.

2. Action Required:
Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

Please state the actions you have taken or are planning to take:
Contact has been made with the registrar for elections in Limerick County Council for the reinstatement of site specific voting opportunities for residents within the nursing home and clarity is still being sought as to why the residents were taken off the special

register of votes.

Person responsible for register of elections in Limerick City Council is currently on annual leave and will not be available until approx. end of July.

All SVI forms have been generated for all residents and signed and have been sent to GP for signing and will be submitted to Limerick County Council.

Proposed Timescale: 31/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While residents were observed to be enthusiastically participating in activities, predominantly in the afternoon, residents were left with limited stimulation in the morning times. On both days of the inspection residents were seen in the sitting room with the television on but none of the residents showed any interest in what was on television.

3. 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:
Since week commencing 2nd June 2019, amendments were made and additional hours were given to the activities coordinators working hours to facilitate more activities for the residents.

Currently the activities programme runs as follows. Monday 10am-4pm, Tues 9am-8pm, Wed 10am-4pm + Bingo 3pm-4pm, Thursday Art Therapy 11-3 + Music 3pm-4pm and Friday 9am-2pm + Mass 3.30-4.15pm.

The additional hours will facilitate arts and crafts sessions, one to one sessions with residents, creative writing, baking session in association with the chef.

Proposed Timescale: 02/06/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A number of residents had their meals in the sitting room and some of these residents had their meals from bed side tables. Because of this, these residents spent most of their day in the one room and meal times were not optimised to enhance the variety of

each resident's day.

4. 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:
All residents and their families have been spoken to and given the choice of where they would like to eat.

7 residents in conjunction with their families have chosen to relocate to the large dining room for their mealtimes in order to enhance their dining and social experience.

This will be reviewed on an ongoing basis and current and new residents will be offered and encouraged to utilise the dining areas for their mealtimes.

Proposed Timescale: 22/06/2019

Outcome 05: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Significant improvements were required in relation to the induction and supervision of staff. For example:
• management arrangements were not effective in adequately supervising staff to ensure that performance was at the required standard or in addressing issues of performance brought to their attention
• while there was an induction process in place for new staff, there was not always a record demonstrating how management were assured of the staff member's competence to perform the role for which they were employed.

5. 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:
Clinical supervision online course will be completed by PIC and CNM2 and will be rolled out to all staff nurses.

Clinical supervision tool – Guidelines for clinical supervision – has been developed and will be rolled out from August 1st 2019.
Formal annual performance appraisal will continue.

Management will address ongoing and individual issues of performance in a timely manner. Issue of general/team performance will be addressed at handover in the

morning and at lunch time.

The induction process will be strengthened and developed to include a formalised daily program for the induction period and a sign off discussion will be held with staff member mentor and management.

Proposed Timescale: 30/06/2019

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had attended up-to-date training in mandatory areas such as fire safety, manual and people handling, safeguarding residents from abuse, or responsive behaviour.

6. 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:
All staff have received fire training as and from the 11th June 2019.
Training matrix and records have been reviewed for all staff and arrangements have been made to ensure that all staff have mandatory training completed.
Manual Handling Training will take place on 9th July.
Behavioural and Psychological symptoms of dementia training will take place on 22nd of July 2019.
All staff currently have safeguarding training completed and in date.

Proposed Timescale: 30/07/2019

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
References were not obtained from a staff member's most recent employer prior to commencing employment.

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

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

References were obtained for that staff member on 22nd May 2019.

Proposed Timescale: 22/05/2019

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:
Some improvements were required in relation to the management of risk, including:
• doors to areas that could potentially pose a risk to residents were not locked, such as the staff room and the laundry
• emergency exits that had recently been installed required review in relation to being accessed by residents that may be at risk of leaving the premises without alerting staff.

8. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
All staff have been informed that fire doors must remain closed including but not limited to the staff room and the laundry.

Signage has been put up in the laundry, staff room and corridors in relation to the closing of doors and the blocking of fire exits.

It is reiterated under health safety and fire safety management that all staff are responsible for ensuring that at all times emergency exits are free for passage.

The nursing home management will actively observe and supervise that this practice is being carried out.

The risk management policy with its adherent hazard identification and assessment of risks will be reviewed to include the emergency exits that have recently be installed in Apartment 33 and Apartment 36. Risk assess to be done

Nominated provider/owners have contacted electrician with a view to installing alarms on both sets of doors in apartment 33 and 36.

Proposed Timescale: 30/09/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to fire safety, including:
• the inspector noted that a mattress was stored on a corridor, close to an emergency exit and could cause an obstruction in the event of an emergency evacuation
• some fire doors were held open with chairs, which would prevent them for operating effectively in the event of a fire.

9. 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:
All staff have been spoke with in relation to the importance of keeping fire exits free at all times and not propping open any door in the nursing home.

The nursing home management will actively observe and supervise that this practice is no longer being carried out.

Electrician has been contacted by nominated provider/owners to put in place closing mechanisms on both nursing station door and oratory door. These mechanisms are appropriate in terms of fire regulations but will allow the residents to use the rooms accordingly and safely.

Emergency exit are no longer a repository for crash mats, mobility equipment or laundry trolleys.

All emergency lighting in the nursing home has been checked and serviced and is fully operational in the nursing home.

Proposed Timescale: 31/07/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Maps used to guide residents and others to the nearest emergency exit required review in relation to identifying your location in the centre in the context of the closest emergency exit. The maps did not identify all cross corridor fire doors and the orientation of the map could be improved in relation to the direction you need to travel to get to the closest area of relative safety.

10. Action Required:
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

Maps are currently being processed in a timely manner and will be completed and submitted by Fire Engineer who supports the home.

On receipt of the maps they will be displayed in prominent and appropriate positions.

Proposed Timescale: 07/08/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Oxygen cylinders were not stored in accordance with recommended practice.

11. 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:
All oxygen cylinders have been removed from the clinical room and have been placed in designated area with cylinder racks and are secure.

One cylinder remains with the emergency trolley for immediate use and one back up cylinder.

Proposed Timescale: 22/06/2019

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:
A review of records identified, that at times, there was a significant degree of staff disharmony among a small number of staff. Where staff members had expressed concern in relation to the performance of other staff, these were not always addressed through the governance arrangements outlined in the statement of purpose. Various members of the senior management team became involved in performance management related issues without a unity of purpose. This contributed significantly to staff disharmony and also impacted on staff performance.

12. 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:
Director of Nursing has been appointed as /from 4th May 2019 and all documentation has been submitted to HIQA Registration. Director of Nursing will be on duty in the nursing home 5 days per week and will sole operational responsibility for the day to day running of the home.

Director of Nursing has completed a Management course QQI level 6 on 28th June 2019.
Attendance and funding for this course has been provided for the PIC by the Provider Nominee.

CNM2 has been appointed and all relevant documentation has been submitted to HIQA Registration Department.

A new interactive approach between operational managers, nominated provider and owners has commenced. This will allow a more direct communication and accountable operational management process to be vested in the Director of Nursing.
Monthly governance/management meeting have commenced. First meeting occurred on 18th of June 2019.

Proposed Timescale: 31/07/2019

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Deficits in governance and management arrangements had a negative impact on residents. For example:
• it was noted that there were a number of complaints from relatives in relation to the level of personal care provided to residents. While each of these were addressed on an individual basis, a theme extracted by the inspector from a review of complaints was that personal care was a recurring topic of complaint
• due to discord within the senior management team, appropriate arrangements were not in place for the effective supervision of staff. As a result, issues in relation to staff performance were not satisfactorily addressed. This had an impact on the day-to-day lives of residents living in the centre and was communicated to the inspector in discussions with residents.

13. 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:
A review of previous 12 months of complaints have been carried out.
It is noted that since January 2019 there have been no complaints in relation to

personal care from relatives or residents.

Both Director of Nursing and CNM2 are currently completing a course on Clinical Supervision.
The role of the CNM2 is that of direct clinical supervision in the nursing home.
Clinical Supervision Tool is completed and will be rolled out by as and from 1st August 2019.
Since 1st March 2019, an hourly nurse walk around has commenced.
All Healthcare Assistants and Nursing Staff now complete their documentation in the dome/communal areas to further increase supervision of residents and staff.

This information has been shared with all disciplines of staff at their respective meetings in June 2019.

Proposed Timescale: 15/08/2019