

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Holy Ghost Residential Home
Centre ID:	OSV-0000591
Centre address:	Cork Road, Waterford.
Telephone number:	051 374 397
Email address:	holyghostreshome@eircom.net
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Board of Trustees of Holy Ghost Residential Home
Provider Nominee:	Hilary Quinlan
Lead inspector:	Gemma O'Flynn
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	59
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 26 October 2016 09:45 To: 26 October 2016 18:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Non Compliant - Moderate
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced, one day inspection, the purpose of which was to monitor ongoing compliance with the regulations. Holy Ghost Residential Centre is registered to accommodate 60 residents who have been assessed being low dependency and hence require minimal support with the activities of daily living. The needs of the residents has determined that full time nursing care is not required, therefore, a nurse is on duty approximately 15 hours per week, which is split over three mornings per week. A registered nurse works in the centre every night from 8pm to 7.30am. The person in charge is also a registered nurse and is in the centre Monday to Friday, 9am to 5pm during which time she provides nursing care as required.

Over the course of this inspection, the inspector met with residents, staff and the person in charge. Residents' views were elicited, practices were observed and documentation was reviewed. There were 11 actions to be addressed following the previous inspection of the centre in February 2015, these were followed up on on this occasion. Of the 11 actions, six had not been satisfactorily progressed.

On the day of the inspection, there were 58 residents in the centre, one resident was in hospital and there was one vacancy. Resident feedback to the inspector was very

positive. All those who spoke with the inspector said that they were very happy living in the centre and were treated very well by the staff who worked there. They said that they had the opportunity to attend regular residents' meetings and that there was plenty of entertainment and activity on offer. Residents confirmed that they felt safe in the centre. The inspector observed staff and resident interactions and found them to be courteous, respectful and very friendly. It was evident that staff knew the residents well and residents said they felt as though they were part of a large family.

Non compliances were identified as set out in the table above and these are discussed throughout the report and in the associated action plan.

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 Quality Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

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

Findings:

The statement of purpose consisted of a statement of the aims, objectives and ethos of the designated centre and a statement as to the facilities and services which were to be provided for residents. It had been reviewed in September 2016.

The information relating to the arrangements for dealing with the review of the residents' care plan as referred to in regulation 5 required amendment to ensure it met the requirements of the regulations. This had been an action following the previous inspection and had not been addressed.

The statement of purpose did not contain the amendments to the internal layout of the centre as confirmed by the person in charge.

Otherwise, the statement of purpose contained the requirements as set out by the regulations.

Judgment:

Non Compliant - Moderate

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

There were sufficient resources to ensure the effective delivery of care, as described in the statement of purpose. There was a clearly defined management structure in place and staff were familiar with and were able to describe same. The person in charge said that she met with the board of management on a monthly basis and meetings included feedback of audit results and review of incidents in the centre such as falls and other significant events.

Since the previous inspection, there had been changes to the use of rooms as bedrooms in the centre. HIQA had not been notified of this change and the required application had not been submitted.

The person in charge stated that three bedrooms had been decommissioned and an apartment in the building had been divided into two new bedrooms and a sacristy had been converted into a new bedroom and the sacristy relocated elsewhere in the building.

The person in charge confirmed that the occupancy levels in the centre had not changed, this was evident on the day of inspection. The rooms in question were shown to the inspector and found to be of the same design and layout of the other bedrooms in the centre. The person in charge was requested to submit the required application retrospectively.

The person in charge stated that she didn't have autonomy over the budget for the centre and explained that all budget requests needed to be approved by 'the board'. She said that 'the board' were very supportive and that there had never been a time where a request had been denied.

A comprehensive audit system was in place and a monthly schedule had been devised to ensure that audits were completed. Areas subject to audit included matters such as falls preventions, governance and management, rights, religious rights and safeguarding. There was evidence of learning from audits and that they brought about improvements such as reminders in bedrooms regarding measures that could be taken to reduce falls as seen by the inspector and confirmed by the person in charge and the associated documentation.

However, the inspector found that the audit process required some further development to ensure it identified all areas requiring improvement such as medication management and care planning. These are discussed further under outcomes 9 and 11 respectively.

The person in charge stated that the monthly audit information would feed into the annual review. However, an annual review for 2015 was not available in the centre. The audits for 2015 were available but the information had not been reviewed and

condensed into an annual report and made available to residents if they so wished to read it. This was identified in the previous inspection.

The person in charge was engaged in a research study affiliated with a local learning institute, the aim of which was to review future care of older adults nationally in order to inform future service provisions. The person in charge said that the study also involved residents, staff and management in the centre. She said that it had provided learning to inform improvements in future care provision and would be recorded in the annual review for 2016.

Records of training provided to the inspector for review were not up to date and therefore it was not clear if all staff had received the required training. For example, there were gaps in the records of elder abuse prevention training provided to staff as they had not been updated, therefore the inspector was unable to verify that all staff had received that training. The person in charge stated that the training had been delivered but due to changes in administration support the training matrix had not been updated.

There was evidence of consultation with residents via a residents' survey in February 2016. This had garnered an approximate 50% response rate and the feedback had been collated and analysed by the person in charge. Overall, the feedback from residents had been very complimentary.

Resident meetings were held as confirmed by residents and meeting minutes. The last meeting had taken place in May 2016. The minutes demonstrated that items discussed included premises information, evaluation results of the residents' survey and residents' input to state that the television volume was too loud.

The person in charge also said that she carried out daily announcements prior to the lunch time meal and this was observed to occur on the day of inspection. Residents said that they were consulted in the running of the centre via their involvement in fundraising for the centre. For example, the last fundraiser had contributed to the purchase of a mini bus that was used to take residents for day trips to areas of interest.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a person in charge of the designated centre. She was a nurse with the required experience in the area of nursing the older person. Staff and residents who spoke with the inspector could identify her and were supportive of her as a manager. She demonstrated knowledge of the needs of the residents and she was engaged in the governance of the centre on a regular and consistent basis and was employed to work 40 hours per week.

She stated that she planned to complete a course in information technology in 2017 so as to assist her to streamline her documentation.

Whilst the person in charge was aware of the regulations that governed the designated centre, she admitted that she was not aware of her statutory obligations in regards to notifying HIQA of the events as set out in the regulations. Therefore, and as discussed in the 'Notifications' outcome, the required notifications had not been submitted. This was discussed with the person in charge on the day and is actioned under outcome 10.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy on and procedures in place for, the prevention and detection and response to abuse dated July 2016. The person in charge stated that all staff had received training in safeguarding vulnerable adults and staff who spoke with the inspector confirmed they had received training, however, training records had not been updated to provide documentary evidence that training had been provided to all staff or that it was up to date.

Staff who spoke with the inspector confirmed that they knew what to do in the event of an allegation or suspicion of abuse and said that there was a no tolerance approach to such matters.

A sample of staff files reviewed had the required vetting disclosure in place, however,

the person in charge disclosed that one staff member was awaiting a vetting disclosure. The inspector reminded the person in charge of her regulatory responsibilities in this regard and verbal and written assurances were given to the inspector that, with immediate effect, this person would not be rostered on duty until the required vetting disclosure was in place.

The provider and person in charge monitored systems in place to protect residents. The person in charge met with residents daily via her normal duties and all residents who spoke with the inspector could identify the person in charge and said that she was approachable if they had any concerns. The resident survey conducted in February 2015 had asked specifically if residents felt safe in the centre.

Residents told the inspector that they felt safe in the centre.

The person in charge was an agent for a small number of residents and she described the processes in place regarding same and these were satisfactory.

There were no residents who had behaviours that were challenging in the centre and restraint was not in use.

Judgment:
Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
The centre had policies and procedures relating to health and safety. There was comprehensive risk management policy in place that met the requirements of the regulations. A risk register was maintained and referenced environmental and clinical risks. However, there was no formal hazard identification process in place to ensure new or changing risks were identified in a timely manner or to ensure that current controls were implemented and sufficient/proportionate. For example, on the day of inspection, it was observed by the inspector that the call bell in the smoking room was missing, the person in charge was unaware of this. It was also observed that some beds were positioned next to radiators. The person in charge confirmed that this had not been identified as a hazard although she did discuss controls that were in place such as thermostatic controls on radiators.

There was a plan in place for responding to emergencies but this required review to

ensure it considered all eventualities, for example, loss of power, loss of water or loss of heating. The person in charge told the inspector of the alternative location that had been identified should a full evacuation of the centre be required, however, this was not clearly stated in the policy made available to the inspector.

The centre had a policy in place for the prevention and control of healthcare associated infections.

An incident report book was available for inspection and it was evident that staff recorded adverse events. Information included details of the event, the subsequent investigation and any preventative measures. Adverse events were included in the audit schedule for review and the results of all audits were discussed quarterly with staff as evidenced in relevant meeting minutes.

A maintenance book was regularly completed by staff and it was evident that matters were addressed in a timely manner.

Staff were trained in safer moving and handling techniques and records made available to the inspector demonstrated that all staff were up to date in this training.

Suitable fire equipment was provided. A daily check of fire exits was maintained and if an obstruction was observed, a note was made of any follow up action taken. Fire evacuation procedures were displayed throughout the centre. Staff were trained and records demonstrated that all staff had received training in 2016. Staff and residents who spoke with the inspector could clearly explain what was required of them should the fire alarm sound.

Service records for the fire alarm and fire equipment were up to date. The smoking room had a fire extinguisher and fire blanket, the latter being an action required following the previous inspection.

Staff and residents confirmed that fire drills took place. Records provided to the inspector on the morning after the inspection showed that there had been one drill to date in 2016. Documentation relating to fire drills held in the centre required improvement. Documentary evidence included only the date and length of time of evacuation which, whilst is good information, it does not provide sufficient detail to enhance learning following the drill or to demonstrate that the arrangements are sufficient. For example: what the drill had entailed, what had gone well and what required improvement was not recorded. It was not clear if all staff had been part of a drill in 2016. The person in charge confirmed that drills had not been carried out at night time or in simulated night time conditions.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There were written policies and procedures in place for the management of medication in the centre. However, it was observed that the medication administration practices were not in line with current guidance for nurses.

The centre received medication in a pre-dispensed dosage system. Checks upon the monthly delivery of medication were made against a list of the residents' current medication provided by the pharmacy, records were maintained for same. Medication was stored safely on the day of inspection.

Records for the management and administration of controlled drugs were found to be in order. This was an action following the previous inspection. A random check tallied with records.

The person in charge stated that if medication was to be returned to the pharmacy, it was collected on the day it was no longer required. However, there were no records maintained to ensure a verifiable, auditable trail was in place to ensure medication was returned as per protocol. For example, there was no signature of the person returning or receiving the medications, there was no record of the medication or number of medications returned.

The inspector observed a lunchtime medication round and noted that medications were administered to the resident and an explanation of the medication was also provided. The medication administration record was then signed. However, there was no prescription available in the designated centre for the person administering medication to check the medication against to ensure it was correct.

Residents who wished to self administer medication were facilitated to do so, however, an assessment to ensure competency to do so was not carried out.

Medication management training had not been delivered to all staff involved in the delivery of medication and given the findings in this outcome, the inspector formed the judgment that further training was required in this area to ensure compliance with current guidance for nurses.

Judgment:

Non Compliant - Moderate

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and,

where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The person in charge had not notified the Authority of occurrences as set out in the regulations. Quarterly returns had last been submitted in June 2015. Further quarterly notifications or where applicable nil returns had not been submitted. Notifications regarding significant injury to residents were not submitted as required. The person in charge stated that this was an omission on her part and she did not know that the three day notifications in regards to significant injury were required.

Judgment:

Non Compliant - Moderate

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

Residents had access to timely medical treatment. The person in charge stated that residents retained their own General Practitioner (GP) and residents confirmed same and confirmed they had adequate access to medical treatment. Residents had access to allied health care services and records and documentation confirmed same. Given their low levels of dependency, residents could visit their GP in their own practice if they so wished.

The assessment and care planning process required review. Neither assessments nor care plans were being completed four monthly as required. This was identified on the previous inspection. The assessment process included assessment of matters such as falls risk; nutrition & oral care; independence level and risk of pressure sore

development.

However, assessments required review to ensure they were comprehensive. For example, where a resident had a history of a chronic mental health issue, assessments were not in place to ensure early detection and appropriate referral if the issue was to manifest again. Whilst it was evident that the person in charge and staff knew the residents well, formal assessments were either not in place or not completed in a timely manner. For example, as discussed in the outcome relating to medication management, assessment for self medicating was not in place. A general smoking risk assessment was completed for residents who smoked but it was not evident that these risk assessments were reviewed four monthly or that they considered all matters that influenced a residents' ability to smoke unsupervised or without intervention, for example, an underlying medical condition.

Where a problem was identified, a specific care plan that clearly set out the problem and the required interventions was not in place. For example, a wound care plan was not in place for a resident who required dressing to a wound. There was no guidance as to the frequency of dressing changes and daily narrative notes did not indicate that the dressing had been attended to. The person in charge stated that this was a documentation oversight and the care had been provided. A care plan for a resident who was deemed to be at high risk of developing pressure sores was not in place, although again, the person in charge was able to outline the interventions in place such as pressure relieving equipment and encouraging the resident to mobilise frequently. For a resident deemed to be at risk of falls, a relevant care plan was not in place, despite the resident having a history of falls in the centre.

Where a care plan was in place, the documentation required review to ensure it adequately directed care. For example, a care plan for a resident with diabetes required review to ensure it was comprehensive. The inspector was satisfied however, that daily records demonstrated that the required checks were carried out. Where a care plan was in place, it required review to ensure it clearly addressed individual issues and contained recommendations made by allied health professionals. On speaking with the relevant staff, it was evident that they were familiar with the recommendations made and that these were implemented.

Residents' signatures were recorded on care plans to confirm their participation in same.

Each resident was assessed prior to admission to the centre and an admission committee oversaw the admission process with the person in charge being the final decision maker. Written consent was obtained for any necessary photography, the prescription sheet and the resident's care record.

Transfer and discharge records were stored in the residents' files.

Judgment:
Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

A sample of rosters were reviewed and staff and residents confirmed that there were adequate staff on duty at all times. As discussed in the introduction, The assessed needs of the residents had determined that full time nursing care was not required, therefore, a nurse was on duty approximately 15 hours per week, which was split over three mornings per week. A registered nurse worked in the centre every night from 8pm to 7.30am. The person in charge was also a registered nurse and was in the centre Monday to Friday, 9am to 5pm during which time she provides nursing care as required. Carers, multi task attendants and household staff provided additional support.

Staff had access to a training programme and staff confirmed same. Not all staff had received up to date CPR (Cardio Pulmonary Resuscitation) training.

Staff had received appraisals in 2015 but they remained outstanding for 2016. This had been an action in the previous report, however meeting minutes and staff confirmed that the person in charge planned to complete the appraisals before the year end.

A sample of staff and volunteer files were reviewed and these met the requirements of the regulations. As discussed and actioned in the safeguarding outcome, a vetting disclosure was not in place for one member of staff. Up to date registration with the relevant professional body was in place in the sample of files reviewed.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Gemma O'Flynn
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:	Holy Ghost Residential Home
Centre ID:	OSV-0000591
Date of inspection:	26/10/2016
Date of response:	28/11/2016

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: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The information relating to the arrangements for dealing with the review of the residents' care plan as referred to in regulation 5 required amendment to ensure it met the requirements of the regulations.

The statement of purpose did not contain the amendments to the internal footprint of the centre.

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

1. Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The Statement of Purpose has been amended to demonstrate the internal reassignment of bedrooms from section 1 to section 2 in order to facilitate improved living for the residents. We retain the same capacity of 60 residents. The revised statement of purpose has been forwarded to HIQA 15.11.16 identifying these changes. as per regulation 03 (1)

Proposed Timescale: 11/11/2016

Outcome 02: Governance and Management**Theme:**

Governance, Leadership and Management

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

Since the previous inspection, there had been changes to the use of rooms as bedrooms in the centre. HIQA had not been notified of this change and the required application had not been submitted.

The audit process required some further development to ensure it identified all areas requiring improvement such as medication management and care planning.

Records of training provided to the inspector for review were not up to date and therefore it was not clear if all staff had received the required training.

2. Action Required:

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

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

1 The required application to vary form has been completed 15.11.16 and forwarded to HIQA informing them of the changes to the use of rooms as bedrooms in the centre.

2 The existing medication audit will be developed in line with a new medication prescription Kardex system to be introduced in collaboration with all residents Medical Practitioners.

The care plan audit will be developed in line with the expansion of the already established resident care files/ The existing care plan audit will be amended to include the updated documentation.

3 The records of training will be improved. The prior training matrix being used up to the end of 2015 will be reinstated to replace the column system for recording staff training this last year 2016.

Proposed Timescale: 31/01/2017

Theme:

Governance, Leadership and Management

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

An annual review for 2015 was not available in the centre. The audits for 2015 were available but the information had not been reviewed and condensed into an annual report and made available to residents if they so wished to read it.

3. Action Required:

Under Regulation 23(f) you are required to: Make available a copy of the review referred to in regulation 23(d) to residents and, if requested, to the chief inspector.

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

We commenced a comprehensive Quality Management Audit System last year 2015 introducing monthly audits meetings and reviews. This was a huge learning experience and led to many service developments. Following on for this year 2016 we developed the process further to include data collection, meetings, audit reviews, timescales, goals and achievements and we are now in position in December 2016 to complete an annual review for the period January – December 2016. It will be available for residents and inspections at end of January 2016.

Proposed Timescale: 31/01/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

There was no formal hazard identification process in place to ensure new or changing risks were identified in a timely manner or to ensure that current controls were implemented and sufficient/proportionate.

4. 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:

We are developing our risk management policy under the regulations ensuring a robust hazard identification and assessment of risks.

We have already this year further developed a Health and Safety audit assessment tool within our quality management system review. It is written up in consultation with our Health and Safety advisor, it is appropriate for the supportive model of care service provision and resources. It is being applied in practice from January 2017 when Health and Safety internal training on this improvement is completed with our Health & Safety representatives and all staff.

A section of audit will be completed daily by the Health & Safety representatives and in conjunction with the person in charge. It comprises a formal hazard identification process and risk rating as in the already existing annual Health and Safety review (minor moderate and major risk rating) and will be prioritised accordingly. It will in practice reinforce our present ethos of prompt immediate action .

However it is a more structured system and will monitor hazards in practice. All results will also feed into our quarterly quality management meetings to record the timescales and person responsible to complete any actions outstanding, while continuing to strive for safety and safety awareness for the residents, meeting their needs and choices within our supportive care setting.

Proposed Timescale: 01/01/2017

Theme:

Safe care and support

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

The emergency plan required review to ensure it considered all eventualities, for example, loss of power, loss of water or loss of heating. The person in charge told the inspector of the alternative location that had been identified should a full evacuation of the centre be required, however, this was not clearly stated in the policy made available to the inspector.

5. Action Required:

Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

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

There is an Emergency / Evacuation / Contingency plan in place for any major incident likely to cause death or injury, serious disruption or damage caused to the home where re-entry is not permissible. Alternative living accommodation is agreed within the plan in conjunction with the HSE (2014). The plan is attached to the fire emergency and evacuation procedure (schedule 5 policies) as per regulation 26(2)

Proposed Timescale: 27/10/2016

Theme:

Safe care and support

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

Documentation relating to fire drills held in the centre required improvement. Documentary evidence included only the date and length of time of evacuation. What the drill had entailed, what had gone well and what required improvement was not recorded. There were no details as to the length of time it would take to evacuate all residents from a specific zone if needed. It was not clear if all staff had been part of a drill in 2016. The person in charge confirmed that drills had not been carried out at night time or in simulated night time conditions.

6. 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:

Our present fire documentation will be improved using the HIQA "Fire Precautions in Designated Centres." Guidance documentation Our existing records will be updated to demonstrate staff understanding and residents awareness of the fire procedure in the home

The development of the documentation will show specific details of the fire drill and specific zone evacuation and demonstrate our learning outcomes from same in line with the regulations.

All staff in the Home have received fire training and are updated annually.

The next fire drill is booked for Dec.2016 and will be a simulated night time drill.

Proposed Timescale: 31/01/2017

Outcome 09: Medication Management

Theme:

Safe care and support

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

There was no prescription available in the designated centre for the person administering medication to check the medication against and thus ensure it was correct.

Medication management training had not been delivered to all staff involved in the delivery of medication and given the findings , the inspector formed the judgment that further training was required in this area.

Residents who wished to self administer medication were facilitated to do so, however, an assessment to ensure competency to do so was not carried out.

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:

1 Following consultation with all residents medical practitioners a new Kardex system for prescribing of the residents medications will be instated in order to have a medical prescription on the residents file. There will now be a GP prescription on file alongside the presently used biodase drug sheet for safe practice in line with regulations.

2 Pharmacy Training for carers and nurses will be updated annually and provided by a registered pharmacist. Next training date is set for Tuesday 14th Nov 2016 at 2.30pm.

3 Any resident self medicating will have a self medication assessment carried out and reviewed 4 monthly or as required this will be documented and recorded on the residents care file.

Proposed Timescale: 31/01/2017

Theme:

Safe care and support

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

There were no records maintained to ensure a verifiable, auditable trail was in place to ensure medication was returned as per protocol. For example, there was no signature of the person returning or receiving the medications, there was no record of the medication or number of medications returned.

8. Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

A Returns pharmacy record book will be commenced and signed by the staff member returning the pharmacy and the pharmacy rep collecting the discontinued medications. It will be signed and dated with the residents name in accordance with Regulation 26.

Proposed Timescale: 30/11/2016

Outcome 10: Notification of Incidents

Theme:

Safe care and support

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

Notifications regarding significant injury to residents were not submitted as required. The person in charge stated that this was an omission on her part and she did not know that the three day notifications in regards to significant injury were required.

9. Action Required:

Under Regulation 31(2) you are required to: Inform the Chief Inspector in writing of the cause of an unexpected death when that cause has been established.

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

The person in charge will forward as per regulation 31(2) the regulatory NF03 form to HIQA Notifications where there is a significant injury to a resident within 3 days and this will be in conjunction with 3 day notifications whereby we return NF01 sudden Death, NF02 outbreak of notifiable diseases, NF05 absence of a resident, NF07 misconduct of provider, NF08 and NF09 loss of power etc.

Proposed Timescale: 27/10/2016

Theme:

Safe care and support

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

Quarterly returns had last been submitted in June 2015. Further quarterly or where applicable nil returns had not been submitted.

10. Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

The quarterly reports using the NF39 and Nil Return form will be forwarded quarterly and a copy retained on file in the Home. 31st Jan, 30th April, 31st July, 31st Oct as per HIQA regulations.

The Oct 31st 2016 quarterly return has been submitted to HIQA from the Home.

Proposed Timescale: 31/10/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

The assessment and care planning process required review. Neither assessments nor care plans were being completed four monthly as required.

Assessments required review to ensure they were comprehensive. For example: Assessments relating to identified medical issues such as depression were not in place to ensure early detection and appropriate referral if required.

Assessment for self medicating was not in place.

A general smoking risk assessment was available for residents who smoked but it was not evident that these risk assessments were reviewed four monthly or that they considered all matters that influenced a residents' ability to smoke unsupervised or without intervention, for example, an underlying medical condition.

Where a problem was identified, a specific care plan that clearly set out the problem and required interventions was not in place.

For example: wound care; pressure area care; diabetes and falls.

11. 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:

1. Our assessments and care file reviews will be expanded and developed with 4 monthly assessments and 4 monthly reviews of the low- independent care plans here in the Home.
2. Assessment for our residents self medicating will be instated and reviewed 4 monthly or as required.(example if acutely unwell)
3. A multi disciplinary team meeting is being arranged with the psychiatric liaison services linked to the home (as we rely on their expertise in relation to individual resident care interventions) to discuss this recommendation of a depression score 4 monthly with regard to specific individualised care. Our main objective is to continue to benefit the residents health and wellbeing at all times. Any resident with a history in their past of depression will be discussed in relation to depression scores and linking into the community health professionals. We are hoping to arrange this meeting for December 2016.
4. Each resident has a risk assessment (risk register) completed with Hazard, Risk Rating and intervention –signed and dated. We will develop this existing assessment to ensure it is more informed and effective within our supportive model of care facility. It will be reassessed every 4 months to ensure safe effective care, meeting the regulatory standard. An internal training session will be undertaken for the caring and nursing staff to ensure full compliance and updating of the risk register.

5. The Residents care file will be developed further demonstrating clearly where the individual residents specific healthcare care needs are identified and addressed. The Carers will receive internal training in the use and ongoing documentation of the nursing care plan and it will be reassessed 4 monthly in the supportive care home as per the regulations.

Proposed Timescale: 31/07/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

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

Not all staff had received cardio-pulmonary resuscitation training..

12. Action Required:

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

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

The date is set for December 2016 for Next CPR training for staff. The person in charge will ensure all staff training for CPR is up to date as per Regulation 16

Proposed Timescale: 31/12/2016