

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sacré Coeur Nursing Home
Centre ID:	OSV-0000278
Centre address:	Station Road, Tipperary Town, Tipperary.
Telephone number:	062 51157
Email address:	selma.kelly@sacrecoeur.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sacré Coeur Nursing Home Limited
Provider Nominee:	Selma Kelly
Lead inspector:	Gemma O'Flynn
Support inspector(s):	Ide Cronin
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	4

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 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 compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 12 October 2016 09:10 To: 12 October 2016 16:50

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Non Compliant - Moderate
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	Substantially Compliant	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also followed up on progress with completion of actions required to address non-compliances with the regulations from the last inspection in the centre in January 2015. There were 4 actions identified from the last inspection. The findings from this inspection confirmed that all actions were satisfactorily completed with the exception of the action in relation to the premises which had not been satisfactorily progressed. A proposed new extension and refurbishment to the existing building to address this non-compliance had not commenced. The provider had advised the inspector, prior to this inspection, of the delays to the premises works and had submitted an application to change the previously agreed date for completion.

As part of the thematic inspection process, providers were invited to attend seminars

which explained the inspection process. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care. Prior to the inspection, the provider completed the self-assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The judgements of the self-assessment and the inspection findings are set out in the table above. There was a total of 22 residents in the centre on the day of this inspection, five residents had a formal diagnosis of dementia and one other resident had symptoms of dementia. The centre did not have a separate dementia specific unit. Residents' accommodation was arranged over three floors level.

Inspectors met with residents, relatives and staff members during the inspection. They tracked the journey of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined the relevant policies including those submitted prior to this inspection. There were policies and procedures in place for safeguarding residents from abuse. Overall, staff were observed to be respectful, supportive and caring towards residents and demonstrated a good awareness of residents' needs. However, on occasions, opportunities for meaningful interactions were not recognized and the care provided was neutral and/or task orientated in its delivery as opposed to positive connective care. It wasn't evident via conversations with staff that they had been made fully aware of recommendations from allied health professionals to ensure that such recommendations were fully implemented.

The provider acknowledged the limitations of the building. It was an old building originally constructed in the early 1900's and had functioned as a military convalescence facility. The original building consists of accommodation on the ground floor, a middle floor and the top floor. A stair case and chair lift serviced the middle and top floor. An extension had been added with further accommodation on the ground floor.

The judgments of the self-assessment and the inspection findings are set out in the table above. Findings are discussed in detail 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: 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:

Residents' healthcare needs were met through timely access to medical treatment. Local General Practitioners (GPs) visited the centre and an out of hours service was also available. Pre-assessment of residents, prior to admission, were conducted to ensure that the residents' needs could be fully met in the designated centre. Records demonstrated that links and referrals were made to specialised services such as psychiatric services. Records demonstrated that residents had access to the services of allied health professionals such as dieticians, speech and language therapists, chiropody and optical.

There were systems in place to encourage the prevention and early detection of ill health, for example, a health promotion assessment was completed every four months and considered such matters as whether the resident smoked, experienced depression or memory loss. Records of regular blood profiling were maintained in the sample of resident files viewed. However, not all systems that were in place for the early detection of ill health were fully implemented across the sample of files reviewed. For example, a monthly weight check or its recommended alternative had not been carried out since June 2016, despite an allied health professional advising its necessity and despite monthly checks being the centre's standard practice. Monthly blood pressure checks had not been completed since June, there was no rationale recorded for this omission, for example, the resident had refused the intervention.

There was a comprehensive risk assessment process in place and this included review of matters such as: dependency levels, nutrition status, skin integrity and likelihood of developing a pressure sore, pain status, falls risk and a depression scale. In the sample of files reviewed, there was evidence that these assessments were completed in the required time but in some instances there was gaps of six months or more in the completion of such assessments and there was evidence that residents needs had changed in that time. For example, in one assessment reviewed for the likelihood of developing a pressure sore, there was a gap of six months. In that time, the resident had moved from being 'at risk' to being 'high risk'. Where there was a history of depression, the required assessment tool had not been completed in over two years,

despite the resident receiving treatment for same in 2016. Although it was evident that the resident had received appropriate referrals and associated treatment, it was not evident that it was done so in a timely manner and in response to changing needs. Therefore inspectors were not satisfied that residents changing needs were identified nor the appropriate interventions implemented in a timely manner at all times.

Care plans were in place for associated health or social problems. Overall, inspectors found that these were person centred in their approach and gave good information that directed care. However, it was evident that despite staff's good knowledge of residents' needs, they were not fully aware of specific instructions from allied health professionals following review and that the associated care plan had not been updated with this specific advice. For example, a dietician's recommendation was not included in a resident's care plan nor the recommendation of a chiropodist and staff were unable to discuss these specific recommendations.

There were systems in place to protect residents from malnutrition and dehydration. For example, a daily log was maintained of residents' food intake and records were available for review. The person in charge discussed the systems in place for preventing or detecting dehydration, however, these were not implemented in all files reviewed. For example, where a resident had been deemed as experiencing dehydration secondary to their medical condition, there was no ongoing assessment of same and nursing daily note records did not consistently record intake or output. The person in charge stated that the resident in question's hydration status had improved over recent weeks, however, there was no record to demonstrate that this conclusion was accurate. However, staff who spoke with inspectors demonstrated via their descriptions of the care provided that ensuring adequate fluid intake was an important part of this resident's care. Inspectors also noted that individual preferences and habits around mealtimes were recorded, for example, the resident's preferred time for breakfast. There was access to fresh fluids throughout the day. The catering staff who spoke with inspectors demonstrated very good knowledge of residents' needs and dietary requirements. A file was maintained in the kitchen of dietary requirements and likes and dislikes. The chef said that she would regularly call into the dining room for feedback on meals and that residents often stopped outside the kitchen to compliment the meals. Resident satisfaction with the food in the centre was seen to be on the agenda for resident meetings.

Resident falls were reviewed individually and annually to identify any contributing factors. Residents' risk of falls was assessed on admission and reassessed every four months or more often if a fall occurred.

There was evidence that residents could refuse care if they so wished and this choice was respected.

End of life care needs were identified on admission and updated accordingly there was evidence of any advance planning to ensure the expressed preferences of residents were taken into account prior to them becoming unwell. Decisions concerning future healthcare interventions were also documented as observed by the inspectors. Resident's preferences with regard to transfer to hospital if of a therapeutic benefit were documented in all of the end-of -life care plans reviewed.

There were issues of capacity to make decisions that staff had to consider as some residents were highly dependent or had dementia or a combination of complex conditions. There was evidence in medical records that end-of life care decisions regarding resuscitation were documented by the GP. There was evidence of discussion or input from residents or relatives on the advance care plan to confirm this decision. An inspector was informed that the policy of the centre was that these decisions were reviewed on a four monthly basis or sooner in light of the changing needs of residents.

Medication management practice and procedures were in line with professional guidelines. Inspectors observed that medications were stored and administered safely to residents by a registered nurse. Inspectors reviewed a sample of administration and prescription records and found that they were in line with prescribing legislation. There were specific tools in use for assessing the pain levels of residents' with dementia. However, there were gaps in the completion of these and where analgesia had been administered to a resident with dementia, the assessment tool was not utilised to determine the efficacy of the medication.

Judgment:

Non Compliant - Moderate

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:

There was a policy on adult protection in place dated June 2016. The inspector observed that the national policy on safeguarding vulnerable adults at risk of abuse policy 2014 was available to staff also. The provider nominee had applied to become a train the trainer in the new national policy on safeguarding and planned to roll out this training to all staff once she had completed train the trainer.

Staff to whom the inspector spoke with were able to confirm their understanding of the features of protection of vulnerable adults and to whom they would report a concern. There was an on going program of training in safeguarding vulnerable adults in place and all staff had up to date training as observed by the inspector. Staff recruitment procedures were in place to ensure residents were safeguarded. All the staff files reviewed held a vetting disclosure. However, the provider informed inspectors that arrangements were in place to supervise a new part-time staff member, who had applied for Garda Vetting but had not received a vetting disclosure from the National Vetting Bureau of An Garda Síochána. This staff member due to the nature of their role did not have direct resident contact as stated by the provider. When inspectors

informed the provider that all staff require a vetting disclosure under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016, the provider took immediate action to address this non compliance and provided verbal and written assurances to HIQA that all employees rostered to work had the required vetting disclosure.

There was a policy on the management of behaviour that is challenging. Staff spoken with were familiar with resident's behaviours and could describe particular interventions well to the inspector for individual residents. During the inspection the inspectors observed that staff approached residents in a sensitive and appropriate manner. There was evidence staff had completed training in behaviours that challenge which was delivered on an annual basis. Where residents had mental health issues they were appropriately referred to the mental health services for assessment and on-going review. Standardised assessment tools were also in use to record antecedents, behaviours and consequences in an effort to determine any triggers and inform the development of care plans. Staff who spoke with inspectors knew the residents well and were familiar of the interventions outlined in the care plans for individual residents.

It was noted that there was a culture of promoting a restraint free environment. There was a restraint register in place. There was a policy on the management of restraint which was in line with national policy. This had been reviewed in January 2016. Five out of 22 residents were using bedrails at their request. Consent for their use had been signed and the inspector viewed the risk assessments which had been undertaken prior to their use. The inspectors were informed that alternative measures such as low low beds, crash mats and bed alarms were in use.

The centre managed some residents' finances. There was a policy on residents' accounts and personal property dated 01 December 2015. The inspectors reviewed the system in place to manage residents' money, and found that it was sufficiently comprehensive to ensure transparency and security. Residents' financial transaction records were signed by the resident and co signed by a staff member. Residents could access their money kept in safekeeping as they wished.

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:
Overall, inspectors found that residents had opportunities to be involved in how the

centre was planned and run. Inspectors reviewed meeting minutes and it was evident from the attendance list that residents with dementia were present and advocated for. The agenda of the meeting included the introduction of new residents and obtaining their feedback on the centre since their admission, the centre's food, heating and general services were all subject to feedback. The person in charge also documented that she visited those residents who chose to stay in their bedrooms to elicit their feedback, although this feedback was not recorded on an individual basis. Not all residents who spoke with inspectors were aware of the residents' meeting forum but did state that they knew who to speak with if they had any concerns or complaints.

There was access to advocacy services and information was displayed on a noticeboard in the entrance hall. A resident with dementia discussed these notices with an inspector. The notice board held information advising residents of the arrangements to vote in house and also advised that residents would be facilitated to vote at local polling booths where possible.

Inspectors observed that residents appeared well groomed and cared for and residents confirmed that staff assisted them with personal care as required. Some residents reported that staff did their best to get to them in a timely fashion to attend to their morning care but there were times where residents had to wait until staff were free which was later than the resident's personal preference.

Inspectors saw that the majority of residents remained in their bedrooms throughout the day. For example, at lunchtime, the dining room which could accommodate 16 people had a sitting of just six residents. Three dined in the sitting room and the remainder in their bedrooms. Some residents who spoke with inspectors said that they preferred to remain in their bedrooms and the provider and person in charge confirmed that this was the case. Because there was only a small number of residents in the day room during the day, interactions between residents were seen to be limited.

There were no restrictions on visiting and visitors were seen to come and go over the course of the inspection.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with a dementia. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents. Observations of the quality of interactions between residents and staff for selected periods of time indicated that the majority of interactions demonstrated neutral or task orientated care and some positive connective care. For example, staff were observed to indiscreetly assist a resident to eat their meal by standing over the resident without any meaningful conversation. Natural opportunities that arose that could provide positive connective care were not always recognised and resulted in interactions without eye contact, explanation or conversation. (This is discussed further under staffing and actioned under that outcome). Staff were observed to be familiar with residents' physical care needs. Efforts to chat to residents about recent news events or daily life were observed and there was times of good banter between staff and residents.

Inspectors observed that the morning time leading up to midday was a time of little

stimulation for residents. Staff confirmed that they were busy with morning care and did not have time to interact with residents unless a specific task was also required. Some residents who spoke with inspectors confirmed that they were often bored and that they would make their own entertainment by going for a walk.

A dedicated activities co-ordinator was in place Monday to Friday 3pm - 6pm. On the day of inspection, the activities notice board had not been updated and held no information for that day's activities. The date that was displayed on the notice board was incorrect and was not amended until the activities co-ordinator came in at 3pm. Staff and residents were unaware of what activities were planned for that day. The person in charge stated that the activities co-ordinator had been on leave, hence the gap in communication for activities. Activities records were maintained and held details of group activities and one to one activities but records did not demonstrate that all residents had access to sufficient levels of social interaction. For example, in the file of a resident with a dementia, showed that the resident who did not take part in group activities had received 13 minutes of activity focused care over the course of one week. The provider and person in charge said that this was not reflective of the interactions that had occurred nor was it reflective of the care plan or activities capabilities assessment that had been completed. Staff who spoke with inspectors confirmed that this resident was checked on at least half hourly.

Occasional outings were arranged for residents and the activities co-ordinator told inspectors of how residents with a dementia had attended and of those who had declined to go. Meeting minutes referenced the summer garden party that had taken place and a choir who had visited the centre. A pet therapy day had taken place and it was evident that residents with a dementia had been included. An outing to a music evening nearby was being planned before the year end. At 3pm the activities co-ordinator and a member of staff were seen to engage in some therapeutic activities with residents in the sitting room. The activities co-ordinator confirmed that all residents would be visited and that there was sufficient time to do in the allocated time.

Staff were able to clearly demonstrate an awareness of residents' communication needs and these were highlighted in the sample of care plans reviewed. There was access to local newspapers, radio and television. Roman catholic clergy celebrated mass in the centre on a monthly basis and Holy Communion was received weekly by those residents who wished to received same. Links with other denominations were in place if required.

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:

The inspectors found that there was an effective system in place for the management of complaints. Residents told the inspectors that if there was an issue they would be happy to raise it with the person in charge.

The inspectors reviewed the complaint's policy and found it to be adequate. It was displayed on the notice board on the ground floor. It met the requirements of the Regulations. It described how to make a complaint, who to make the complaint to and the procedure to be followed on receipt of a complaint. It also contained an independent appeals process. There was a system in place to record verbal and written complaints.

On review of the record of complaints, there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

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 inspectors found that the numbers and skill mix of staff was appropriate to the assessed needs of residents and the size and layout of the centre on the day of inspection. An actual and planned staff roster was in place. Staff numbers were on duty as outlined on the roster. The inspectors observed that staff delivered care in a respectful and safe manner. However, some residents told inspectors that at times they would need to wait until a time later than their preference to receive personal care. Staff told inspectors that overall, staff was adequate to meet the physical and social needs of residents but that morning times could be busy. The person in charge confirmed that she had autonomy to allocate extra staff to a shift if required, for example, if a resident was unwell.

There was a written staff recruitment policy in place. The inspectors reviewed a sample of staff files and found that the required documentation was in place in line with the requirements of Schedule 2 of the Regulations. The inspector observed that An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers for nursing staff were in place in the sample of files reviewed. There were no volunteers working in the centre

on the day of inspection.

Records reviewed confirmed that all staff had mandatory education and training in place. Staff had also been provided with other training on a variety of topics, such as infection control, falls management, responsive behaviours and health and safety. This enabled staff to provide care that reflects current best practice. Staff spoken with told inspectors their learning and development needs were being met and they demonstrated an adequate knowledge of policies and procedures. Inspectors found that further training was required in person centred care as at times as discussed in the outcome relating to residents' rights and dignity, it was observed that care delivered was task based and neutral in its approach.

A daily communication system was established to ensure timely exchange of information between shifts which included updates on the residents' condition. There was evidence of regular staff meetings taking place the last one had been held on 20 September 2016. The inspectors observed that staff appraisals took place on an annual basis.

The inspectors spoke with all staff members on the day of inspection and found that they were knowledgeable about residents' individual needs, fire procedures and the system for reporting suspicions or allegations of abuse. Staff told the inspector that they were well supported and said that the person in charge and provider provided good leadership and guidance.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

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:
The designated centre was originally established in the early 1900s and was used as a military convalescence facility. Issues identified in the previous inspection had not been satisfactorily progressed. The provider had been in contact with the inspector prior to the inspection to advise of the delays to the proposed works to address the non compliances previously identified. An application to change the proposed completion date for works had recently been submitted.

Resident accommodation was provided over two storeys, with bedrooms located on the ground floor, a middle floor which was split level to the top floor. There upper floors were serviced by a twisting staircase and a chair lift. One shared bedroom had two steps

leading into it. Eleven residents were accommodated on the ground floor which consisted of 3 single bedrooms, without ensuite facilities; two single bedrooms with full ensuite facilities and two three bedded rooms without ensuite facilities. On the previous inspection, issues pertaining to inadequate space in a three bedded room had been identified and the provider had undertaken to complete works to address this as discussed above these works had not commenced. On this occasion, it was also identified that there was insufficient seating in a three bedded room should all residents choose to sit for a while in their bedrooms, it wasn't evident that there was sufficient space for an extra chair given the layout of the room and its furniture. The shared television was not visible to all residents if they were in bed as it was placed high on a wardrobe. Residents confirmed they had adequate storage. Residents who spoke with inspectors stated they had adequate privacy. There were two communal toilets on the ground floor.

The middle floor consisted of three twin bedded rooms without ensuite facilities and the top floor had one single and four twin bedded rooms, non of which were ensuite. The upstairs bedrooms had access to two bath/shower rooms.

Bedrooms were seen to be individualised, including the bedrooms of those with a dementia, although, besides one room, they weren't individually identified to assist residents to recognise their rooms.

There was signage throughout the centre and the person in charge stated that there were further improvements planned in the provision of signage and pictorial signage. Given the layout of the building, inspectors agreed that this would be beneficial to residents in orientating them to the space in the centre. The provider had arranged for bathroom doors to be painted a contrasting colour to assist residents with dementia and contrasting toilet seats were planned. The person in charge had recently taken delivery of specific clocks and calendars to assist residents with a dementia, these were soon to be put in place.

A day room, a dining room and a small well appointed visitor's room was provided on the ground floor. The dining room was set up to seat 16 residents, the person in charge stated that this met the current needs of residents and said that if more residents wished to utilise the dining room, two sittings for meal times would be arranged.

On the day of inspection, the centre was clean and free from odour. Overall, the centre was well maintained with some areas requiring minor decorative upgrade as it had been damaged by equipment passing through, this was discussed with the provider who outlined plans to address same. There was a well maintained, attractive outside space and the doors to this area were seen to be open over the course of the inspection.

Judgment:

Non Compliant - Moderate

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:	Sacré Coeur Nursing Home
Centre ID:	OSV-0000278
Date of inspection:	12/10/2016
Date of response:	28/10/2016

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: 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:

Assessments that were undertaken to inform the develop of associated care plans were not always completed on a four monthly basis, for example, depression scale assessments, pain scale assessment, likelihood of developing a pressure sore. Therefore it was not evident that residents' changing needs were identified in a timely manner.

Care plans were not updated or revised with advice from allied health professionals

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

such as a dietician or a chiroprapist to ensure advice was implemented on a consistent basis.

1. Action Required:

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

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

In relation to the four monthly assessments, the PIC is currently auditing all care plans to ensure that all four monthly assessments are up to date. The PIC will ensure that such assessments are completed on a minimum four monthly basis consistently going forward.

With regard to the recommendations from allied health professionals, the PIC is currently auditing all care plans to ensure that all advices are implemented on a consistent basis going forward.

Proposed Timescale: 30/11/2016

Theme:

Safe care and support

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

It was not evident that advice from allied health professionals was implemented at all times as staff were not fully aware of specific advice from such professionals.

Monthly interventions to encourage the prevention and early detection of ill health were not always implemented such as weight checks or blood pressure checks.

2. Action Required:

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

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

With regard to the recommendations from allied health professionals, the PIC is currently auditing all care plans to ensure that all advices are implemented on a consistent basis going forward.

With regard to the monthly interventions to encourage the prevention of and early detection of ill health, the PIC will cover this in her audit of care plans and will ensure that same are completed consistently going forward.

Proposed Timescale: 30/11/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

Inspectors observed that the morning time leading up to midday was a time of little stimulation or interaction for residents.

Staff and residents were unaware of what activities were planned for that day.

Some residents who spoke with inspectors confirmed that they were often bored and that they would make their own entertainment by going for a walk.

Records did not demonstrate that all residents had access to sufficient levels of social interaction.

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:

The PIC will consult with residents and staff to identify what changes could be made to the current activity programme in order to ensure that residents meet their preferred social and activity needs and to further support positive staff/resident interactions.

The activities board is normally updated daily, however this was not the case on the day of inspection unfortunately due to the activities co-ordinator returning from annual leave that day. The PIC has spoken with the activities co-ordinator with regard to ensuring that in her absence, the planned activities are communicated to staff and residents effectively for the full duration of any absences.

The PIC is currently reviewing the system for recording activities, to ensure that the full range of interactions with residents are recorded on a consistent basis

Proposed Timescale: 30/11/2016

Theme:

Person-centred care and support

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

Not all residents were aware of the residents' meeting forum.

4. Action Required:

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

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

The PIC informs every resident before the resident's meeting and will continue to do so and will document same.

Proposed Timescale: 31/10/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Inspectors found that further training was required in person centred care because at times, it was observed that care delivered was task based and neutral in its approach.

5. 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 PIC will provide further training to staff on person centered care, to ensure that positive connected care is delivered on a consistent basis going forward. The PIC will keep this matter under review going forward.

Proposed Timescale: 30/11/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

Issues pertaining to adequate space in a three bedded room had been identified on the previous inspection and the works to address same had not commenced.

There was insufficient seating in a three bedded room should all residents choose to sit for a while in their bedrooms, it wasn't evident that there was sufficient space for an extra chair given the layout of the room and its furniture.

The shared television was not visible to all residents if they were in bed as it was placed high on a wardrobe.

Signage in the centre required development, so as to fully assist residents with a dementia.

Some areas requiring minor decorative upgrade as it had been damaged by equipment passing through.

6. Action Required:

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

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

The provider is progressing an application to HIQA to vary the agreed completion date for the proposed works to the premises.

In the meantime, the provider will look at a re-configuration of the three-bedded room to ensure that there is adequate seating space for all residents. In addition, the provider will install a second television in that room to ensure that same can be viewed by all residents from their bed.

The provider will continue to develop the dementia signage in the building.

Any required minor decorative repairs will be done as required.

Proposed Timescale: 30.11.16 for reconfiguration and install of new tv. 31.12.16 for additional dementia signage.

Proposed Timescale: 31/12/2016