Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Sligo Nursing Home
Centre ID:	OSV-0000363
Centre address:	Ballytivnan, Sligo.
Telephone number:	071 914 7955
Email address:	sligonursinghome@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Services Unlimited Company
Provider Nominee:	Pat Shanahan
Lead inspector:	Marie Matthews
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	54
Number of vacancies on the date of inspection:	8

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
09 February 2017 09:00	09 February 2017 19:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

The purpose of this inspection was to follow up on the actions required following the last inspection in October 2016. The inspector focused on the outcomes where non compliances were identified on the previous inspection. The inspection was unannounced and took place over one day. There were 54 residents accommodated on the day of inspection. The centre is registered to accommodate 62 residents. As part of the inspection the inspector met with residents, relatives and staff members. The inspector observed and reviewed documentation such as care plans, medication records clinical and operational audits, accident records, complaints and staff files. The inspector also reviewed incidents notified to the authority.

The inspector found on this inspection that the provider had not obtained vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for two new staff before they commenced employment. A similar

breach was identified on the previous inspection. A warning letter was issued to the provider post the inspection and he subsequently confirmed that these staff had been removed from the rota.

A new Assistant Director of Nursing had been appointed since the last inspection and there was improved supervision of staff. One to one training was been provided by the new staff member on care planning. New nursing and care staff had also been recruited to fill vacant posts. A significant improvement was identified in relation residents care plans and a review of all care plans was in progress. The quality of the clinical information recorded gave a clearer picture of the residents needs. There was better evidence of specialist advice in the care plans. The provision of better social care to meet the needs and interests of residents had not been addressed at the time of inspection; however the provider was still within the agreed timeframe to complete these actions.

A management system was in place to ensure the service provided was safe but it required review to ensure that appropriate improvement plans were developed in response to deficits identified and further audits were completed to ensure continuous improvement. The provider had been requested to review staffing levels on the previous inspection and although levels increased temporarily the improvement was not sustained and staffing levels. This outcome is moderately non-complaint as the evidence suggests there is an insufficient number of staff available in the evening time to meet residents' needs. These matters are discussed in the body of the report and outlined in the action plan at the end of this report.

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

Outcome 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:
On the previous inspection, the inspectors identified a significant failure in centre management as 12 staff did not have vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The inspector again reviewed staff files and found that the provider had not obtained vetting disclosures from the National Vetting Bureau of An Garda Síochána for 2 staff recently recruited. A warning letter was issued to the provider requiring him to address this and to submit written confirmation that all staff working in the centre have been appropriately vetted. This is discussed further and an action is included under outcome 5.

A new Assistant Director of Nursing ADON had been appointed since the last inspection and was now in post. She reports directly to the person in charge and works full time. She demonstrated good clinical knowledge. The inspector found evidence of improved clinical supervision of staff. The ADON was involved in supervision of staff, auditing of care planning and staff training. She also attended the staff handover meeting from the night shift to the morning shift every day.
The person in charge said that she and the ADON and the Clinical Nurse manager took it in turn to be on call at weekends and were available to respond to any issues which arose, however senior staff were not routinely included on the rota for weekends to ensure appropriate supervision of staff at weekends.

A report on a review of the quality and safety of care in 2016 was reviewed by the inspector. The report included an action plan to improve the service. The review reported on clinical areas such as pressure wounds, falls, accidents and incidents, complaints, deaths and weights. A management meeting was held to discuss the findings and an improvement plan was developed to address areas of non compliance. On review of the information provided during the inspection, the inspector found that

the action plans developed from this review did not relate directly to the findings. For example, one finding which was referenced in the report was that 25 residents had developed pressure ulcers during 2016. The action plan available didn't reference any strategy to address this issue. Similarly, the number of unwitnessed falls sustained by residents was referenced in the report but the action plan did not refer to any falls management strategy to reduce the incidence of falls.

A staffing review was completed since the last inspection and additional staff had been recruited. The staffing rota provided for December showed that additional resources were deployed to meet residents' needs at that time. However, on the day of inspection, the staffing levels had reverted back to those in place at the time of the last inspection. The person in charge said that this was because the dependency levels of residents were now lower. In conversations with relatives and staff members, inadequate staffing levels were a repeated concern raised by them. The provider has been requested to revisit this issue. This is discussed further and an action has been included under outcome 18.

Judgment:
Non Compliant - Major

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
As discussed under outcome 2, schedule two requirements were not met for all staff working in the centre as two staff recently recruited did not have a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (as prescribed under Schedule 2).

On the previous inspection the inspector identified that some care records were poorly completed and some care plans lacked sufficient detail to guide care. There was significant improvement observed during this inspection. This is discussed further under outcome 11.

Judgment:
Non Compliant - Moderate

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

Findings:
The inspector verified that there were no notifications of abuse since the last inspection or any active incidents, allegations, or suspicions of abuse under investigation. Staff had received training in adult protection and safeguarding residents to protect them from harm and abuse. The person in charge provided training on adult protection and prevention of elder abuse training. Staff spoken with knew what constituted abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to.

Some residents had behavioural and psychological signs associated with their dementia (BPSD). The inspector read a sample of care plans and saw that efforts were being made to identify and alleviate the underlying causes of residents' behaviour and possible triggers were identified and recorded. Staff spoken had completed training in BPSD and were familiar with appropriate interventions to use.The behaviour support plans reviewed had both proactive and reactive interventions identified to help ensure residents with behaviours were supported and their anxieties reduced.

Residents who spoke with the inspector said they felt safe and able to report any concerns. Relatives spoken with also shared this view. The person in charge said they were working towards achieving a restraint free environment and restraint use had reduced since the last inspection. There were 20 residents with bed rails in situ. The inspector noted that where restraint was used safeguarding controls had been implemented. A risk assessment was completed where a restraint was used, to determine the suitability of the restraint for the resident and there was evidence that alternatives options such as low entry beds and sensor mats were tried used first before deciding on restraint use. The inspector found that the use of restraint was in predominately in line with the national policy guidelines. Consultation with residents and representatives was evident in files, but was sometimes recorded in different places on the electronic care planning system 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
On the previous inspection, inspectors identified poor management in relation to falls prevention and a high incidence of unwitnessed falls. The inspector reviewed the files of residents who had sustained a fall since the last inspection. There was comprehensive information recorded on the accident form which was store electronically. This included details of the incident that occurred, the time of the incident, a record of whether the incident was witnessed or unwitnessed, the location of the incident and whether the general practitioner (GP) and next of kin had been contacted. Any contributing factors were recorded and existing risk prevention measures were recorded. The inspector saw that neurological observations were completed post falls to monitor neurological function. A falls risk assessment was completed and the residents' falls management care plan was updated following the fall. There were falls management strategies in place such as low entry beds, sensory alarms and supervision by staff.

The accident and incident records for the four month period since the last inspection indicated that a high number (80%) of the falls that occurred were still unwitnessed. Some of these related to the same resident who had repeated falls. Eight of the unwitnessed falls occurred in communal areas. The person in charge stated that dependency levels were higher the period between October and December but stated that the number of falls had decreased during January and February. An analysis of the records highlighted the need for increased safety checks on residents and improved supervision of communal areas. An action on supervision has been included under outcome 18.

On the previous inspection there was inconsistent recording of daily checks on fire escape routes and fire safety checks were been not completed every day. During this inspection the inspector found the procedures in place to ensure fire safety was monitored. Daily fire exit checks and weekly fire alarm checks were recorded in the fire safety register. Fire doors that automatically close were also checked daily to ensure they were operational. Regular fire drills were being completed and staff on duty could tell the inspector what happened when the alarm was activated.

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:
The inspector reviewed an administration record in the course of the inspection for a resident with a wound who was prescribed a protein supplement and found that a resident was not been administered with the supplement in accordance with the prescription. This was brought to the attention of the person in charge and the ADON who followed up the matter up with the pharmacy during the inspection.

Judgment:
Substantially Compliant

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

Findings:
On the previous inspection an allegation of suspected abuse had not been appropriately notified to the Authority as required by the regulations. The inspector reviewed a sample of the centres records of incidents and accidents that had occurred since the last inspection and cross referencing these with notifications submitted to the authority. All required notifications had been appropriately submitted. Quarterly notifications had been submitted to the Authority as required.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care.

The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
The inspector followed up the areas which required improvement at the previous inspection which related to care plans and found that substantial work had been completed. The person in charge and the ADON had completed an audit of care plans and were in the process of updating all care plans to ensure that they were person centred and reflected the residents needs. Significant improvement was noted in those that had been updated since the last inspection and this work was ongoing. One-to-one training on care planning sessions had been provided to nursing staff. A named nurse system had been introduced with each nurse having responsibility for certain residents. The timeframe agreed with the provider in response to the last inspection had not expired and the person in charged stated that all care plans would be reviewed within the agreed time frame.

Residents' healthcare needs were well met and a record of their care was recorded every morning and evening in their narrative notes. Clinical assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and continence needs. The person in charge visited perspective residents at home or in hospital prior to admission to assess their needs. A comprehensive assessment was completed on admission. There was evidence of the families of residents where consultant in the sample of care plans reviewed however this was inconsistently recorded on the electronic care planning system. The care plans reviewed were more person centred and contained more comprehensive information to guide care.

As this work was on-going and some care plans had yet to be reviewed, this action is repeated in the action plan that accompanies this report.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

Findings:
On the previous inspection, the inspector identified that some complaints had not been appropriately recorded and investigated. The inspector reviewed the centres complaints log which was maintained electronically. All recorded complaints had been investigated. With the exception of one complaint, those recorded were resolved and there was evidence of communication between the centre and the complainant and the satisfaction of the complainant with the outcome of the complaint was recorded.

Judgment:
Compliant

Outcome 15: Food and Nutrition
Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:
Person-centred care and support

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

Findings:
The findings of the last inspection were that the systems for ensuring residents had nutritious food and sufficient fluids were not adequate. The inspector reviewed the systems in place and the supervision of residents' nutrition and hydration needs. There was good access evident to a dietician and to a speech and language therapist. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Those identified as been at nutritional risk were referred to the dietician and a nutritional care plan was put in place. There was evidence that residents were weighed monthly. Nutrition was monitored as part of the quality and safety review and the electronic care planning system provided reports on changes in residents weights and allowed comparison on a monthly basis.

The inspector reviewed the care of residents identified as losing weight and saw that they had been referred to the dietician. Their dietary needs were communicated directly to the catering staff. Nutritional care plans were developed for residents at risk and in most care plans reviewed these contained detailed information regarding the residents nutritional status, their likes and dislikes and included any modifications to their diet such as increased protein for residents with wounds or high calorie diets for those losing

weight. The inspector saw that the advice of the dietician and speech and language therapist was included in the care plans.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
On the previous inspection, the inspector identified that there was no independent advocate available for residents who had a cognitive impairment and that relatives did not attend the resident meetings. This issue also arose on previous inspections and the provider stated in the action plan response "all future residents meetings would include the relatives of cognitively impaired residents to represent their views". The inspector saw that the person in charge had written to relatives inviting them to attend the centre to discuss care plans. She also confirmed that an independent advocacy service had been secured to provide an advocacy service in the future to residents unable to participate in the residents meetings. The provider was still within the timeframe agreed with the authority following the previous inspection to complete this action.

At the last inspection, the inspector identified that there was poor evidence of any meaningful one to one activities for residents unable to participate in group activities or who spend most of the time in bed; and that there was poor availability of assistive technology to assist residents with impaired communication. The provider stated in the action plan response to the last inspection report that the nursing team would work with the resident, their representatives, the activity coordinator and care staff to ensure that a resident centred, care plan was developed which reflected the social needs of residents and staff would receive training in the social model of care. In the sample of care plans reviewed there was poor evidence that this had occurred. There was a schedule of activities in place which included a therapeutic programme for residents with dementia but there was no evidence that this was based on the residents interests and there was no system of recording the activities attended. No assistive technology had been provided for residents with impaired communication. The provider was still within the agreed timeframe to complete these action and the person in charge stated that

these issues would be prioritised. These actions are repeated in the action plan that accompanies this report and will be reviewed on the next inspection.

Judgment:
Substantially Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
On the previous inspection the inspector identified that residents property was not adequately protected as records of their belongings were not appropriately maintained. This action had been addressed and a property list for each resident was now maintained in their bedroom.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:

At the last inspection it was found that there was not a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for 12 staff prior to appointing them. The provider was immediately advised to address this and subsequently confirmed that these staff were removed from the rota until a vetting disclosure was received. As identified under outcome 2, the inspector again found on this inspection that the provider had appointed two staff without a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 A warning letter has been issued to the provider in respect of this breach of the regulations.

On the previous inspection, the inspector identified that the staffing levels/deployment was not appropriately to ensure the residents of residents were met. The inspector judged that the action required had not been adequately addressed. From a review of documentation during the inspection and discussions with the PIC, relatives and with staff the inspector found that the allocation/deployment of staff was still not appropriate to ensuring resident's needs were met.

An assistant director of nursing had taken up a position and 3 nurses and five care assistants been appointed since the last inspection to replace staff who had left and to cover sickness and leave. Some new staff were still completing their induction on the day of the inspection and were employed on a supernumerary basis. However, the rota showed no overall increase in staffing levels (other than the ADON post). The person in charge commented that she increased staffing levels in December as a resident had become unwell. This was confirmed by staff and indicated on the staff rota.

The normal staffing allocation according to the staff rota was:
-Three nurses and eight care assistants during the day from 08.00 until 4pm,
-Two nurses and seven care assistants in the evening until from 4pm to 8pm
-Two nurses and three care assistants at night.

There were 54 residents in the centre and over 60% were assessed as having maximum or high dependency care needs. Most residents had a range of healthcare issues and the majority had more than one medical condition. The centre is laid out over two floors with two units on each side of a central lobby on each floor. A review of accidents and incidents from the previous year included in the centres annual quality and safety report indicated that of the 199 falls sustained by residents in the previous year, 58% were unwitnessed and 25% of the unwitnessed falls that occurred since the last inspection took place in communal areas in communal areas. Two relatives spoken with commented to the inspector that there was not enough staff available in the evenings to assist residents. Some staff also commented negatively on the staffing levels. The provider has been requested to re-review levels of staffing and to increase/ deploy staff appropriately to meet the assessed needs of residents.

In the sample of staff files reviewed, all of the information required by schedule two of the regulations was present with the exception of vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for two staff working in the centre. In one file reviewed, there were gaps in the staff members' employment without an explanation.

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:

Marie Matthews
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 report[1]

Centre name:	Sligo Nursing Home
Centre ID:	OSV-0000363
Date of inspection:	09/02/2017
Date of response:	05/04/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The report on a review of the quality and safety of care did not include a comprehensive improvement plan related to the findings of audits completed.

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

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

such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
• The PIC completes a weekly report on quality and safety. This forms the basis for regular monitoring and review of quality and safety, capability and capacity in the centre. This information is used to undertake monthly, quarterly and annual review reports on quality and safety and to agree appropriate actions, interventions and management strategies for quality improvement.
• The PIC holds a monthly management team meeting in the centre in order to review quality and safety. This includes a comprehensive review of weekly key performance indicators, including: resident profile and dependency levels; clinical documentation, clinical risk, health and safety, scheduled audits, resident/relative feedback and staffing/HR issues.
• An Action Register will be compiled following each monthly management team meeting and this will identify improvement plans and outline the development of associated actions. Target dates will be set for achievement of actions. The Action Register will be reviewed and updated on a monthly basis.
• There will also be a quarterly review of specific aspects of quality and safety (for example slips, trips and falls), which will provide an opportunity to focus in greater detail on the strategy for prevention, management and reduction of risk in the centre. Each quarter a designated aspect of quality and safety will be reviewed and the implementation of a quality improvement plan will reflect a positive outcome for residents.
• The annual review of quality and safety will be informed by the above; this will include a comprehensive improvement plan related to the review of audits and key performance indicators and will incorporate customer survey reports and consultation with residents and a review of feedback and service improvements resulting from residents' and family meetings.

Proposed Timescale: 31/03/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two staff recently recruited did not have a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (as prescribed under Schedule 2).

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

Please state the actions you have taken or are planning to take:
Both Staff members have received Garda vetting disclosures in accordance with the National Vetting Bureau.

Proposed Timescale: 17/02/2017

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:
An analysis of the accident and incident records for the four month period since the last inspection identified the need for increased safety checks on residents and improved supervision of communal areas.

3. Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
• The importance of resident supervision is promoted at all times. Staff will be allocated to supervise all communal areas and resident bedrooms.
• The PIC will ensure that a safe and comfortable environment is maintained by implementing regular nursing and care rounds to check on residents, to ensure that their safety is maintained and that their fundamental care needs are met.
• All staff, including housekeeping, catering, maintenance are aware of the importance of remaining vigilant around promoting resident safety.
• The PIC will ensure that all incidents are reported, documented and assessed, investigated and reviewed. All notifiable incidents are notified to the Authority appropriately as required.
• The PIC will ensure that appropriate interventions to improve resident safety are developed, communicated to staff and documented in care plan. Learning outcomes following incidents and accidents will inform care plan improvements and these will be reviewed at monthly management team meetings.

Proposed Timescale: 31/03/2017

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:

A resident with a wound who was prescribed a protein supplement had not been administered with the supplement in accordance with the prescription.

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

Please state the actions you have taken or are planning to take:
The resident who was prescribed the protein supplement was refusing the supplement and this was documented on the MARS sheet. All supplements are administered as prescribed in accordance with the direction of the prescriber, taking the advice of the pharmacist into account.

Proposed Timescale: 02/03/2017

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:
In the sample of care plans reviewed, some still did not provide sufficient guidance to guide care and to reflect the residents individual needs.

5. 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:
• Prior to admission, the PIC will undertake a thorough pre-admission assessment of resident's care needs to ensure that the home can cater for the care needs of each resident.
• The PIC will ensure that a comprehensive assessment of resident care needs is documented on admission.
• This comprehensive assessment will serve to inform initial care plan development in line with the resident's needs and personal preferences/wishes; the care plan will be prepared within 48 hours of admission to the centre.
• Care plans will be resident focused and based directly on the assessed care needs and personal wishes of the residents.
• Care plans will be communicated to all care staff through increased and improved clinical and care supervision.
• Nurses and care staff will discuss individual resident care plans on a regular basis and care staff will be encouraged to advise nurses on any changes to the required plan of care.

Proposed Timescale: 31/03/2017

Outcome 16: 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:
The inspector observed that some residents spend long periods in their bedroom. There was poor evidence of any attempts to provide any meaningful one to one activities to suit the needs, interests and capacities of these residents.

6. 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 Health & Wellbeing/Social care plan will be reviewed and developed to enhance and improve the social care needs and quality of life of each resident. The care plan will be developed in consultation with residents and families where practicable and appropriate.
• All staff will receive ongoing training in relation to the promotion of health, social care and quality of life. This will incorporate the importance of delivering respectful and dignified delivery of care and safeguarding of residents.
• The nursing team will work with residents, their representatives, the Activity Co-ordinator and care staff to ensure that a person-centred care plan is developed which reflects the social needs of each resident.
• The programme of activities will include one to one interventions where appropriate, including provision of activities for residents who choose to stay in their own rooms.
• The programme of activities will be displayed in all communal areas.

Proposed Timescale: 30/04/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no relatives actively attending the resident meetings and no independent advocate available for residents who had a cognitive impairment or could not attend the meetings.

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

Please state the actions you have taken or are planning to take:
• The PIC will provide an independent facilitator to chair resident meetings.
• The PIC will produce a schedule of resident meetings for the year and display this in the nursing home entrance and communal areas.
• Relatives will be informed of the meetings schedule.
• SAGE have agreed to provide an advocacy service for the residents of the nursing home.

Proposed Timescale: 30/05/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that any efforts were made to use assistive technology to aid residents with impaired communication to communicate and improve the residents' quality of life.

8. Action Required:
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

Please state the actions you have taken or are planning to take:
• The PIC will ensure that the nursing team develops a plan with the resident/representative and the care team which address the resident's assessed communication needs and reflects their personal preferences and choices.
• The PIC will ensure that appropriate specialist referrals are made for residents who require review of vision and hearing.
• The PIC will ensure there is access to the internet for those residents who wish to access web-based communication.
• Communication technology such as Skype will be made available when required through the provision of a tablet device.

Proposed Timescale: 31/03/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number and skill mix of staff was not appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated

centre.

9. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
• The number and skill mix of the staff is based on the number of residents, their assessed care needs and dependency levels, and the geographical layout of the centre. Following a review we have increased staffing levels to enhance supervision of communal areas.
• The Assistant Director of Nursing (ADON) works full-time on a supernumerary basis; her role includes monitoring work flows, staff allocation and delegation of duties appropriate to the skillsets, experience and qualifications of staff; she will ensure that there is a system of effective and supportive teamwork in place and that staff are facilitated to provide a high quality of person-centred care to our residents.
• The PIC will ensure that the number of staff on duty takes account of the number and dependency levels of residents, including clinical conditions.
• The PIC will ensure that the number of staff on duty takes account of unanticipated eventualities and occasions, such as an outbreak of infection or where an individual resident may require one to one care; in such circumstances the PIC will review existing staffing arrangements and ensure that an appropriate number of staff are rostered on duty to enable staff to consistently meet the care needs of all residents in the centre.
• The PIC will ensure that that there are systems in place to ensure appropriate and regular supervision of residents who are at risk of falls and will ensure effective supervision of communal areas. Regular rounds and safety checks will be undertaken to ensure that residents' safety is maintained at all times.
• Care staff will receive continuing direction, delegation and supervision from the ADON and nursing staff.

Proposed Timescale: 31/03/2017