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:	Sullivan Centre
Centre ID:	OSV-0000494
Centre address:	Cathedral Road, Cavan.
Telephone number:	049 432 6000
Email address:	pauline.townsend@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Rose Mooney
Lead inspector:	PJ Wynne
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	18
Number of vacancies on the date of inspection:	3

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 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:	To:
04 April 2017 08:45	04 April 2017 17:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Non Compliant - Moderate
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Compliant
Outcome 15: Food and Nutrition	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection, carried out by the Health Information and Quality Authority (HIQA). The centre can accommodate a maximum of 21 residents who need long-term care, or who have respite care needs. The inspector reviewed progress on the action plan from the previous inspection. Notifications of incidents received since the last inspection were reviewed on this visit.

The purpose and objective of the service as outlined in the Statement of Purpose 'is to provide a quality residential service to older people who have a diagnosis of dementia'. Eighteen residents are accommodated on a long term basis. Three beds are designated for respite care for a maximum period of two weeks.

Policies and procedures were in place to guide staff. Residents had good access to general practitioner (GP) services. There was evidence of regular medical reviews by the GP.

There was an adequate complement of nursing and care staff on each work shift. In addition to mandatory training required by the regulations staff had attended training on infection control, nutritional care, cardio pulmonary resuscitation techniques and end-of-life care in the recent past.

The building was well maintained, warm, comfortably decorated and visually clean. There are a number of different sitting rooms available for use by residents. The majority of the residents attended the dining room or day sitting room for their main meals. Residents were offered a varied, nutritious diet.

The action plan at the end of this report identifies areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: 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):
No actions were required from the previous inspection.

Findings:
The statement of purpose detailed the aims, objectives and ethos of the centre. It outlined the facilities and services provided for residents and contained all information in relation to the matters listed in schedule 1 of the regulations.

The provider understood that it was necessary to keep the document under review. It was updated January 2017 to reflect the changes in the number of beds available for respite care and long-term care. The number of respite beds has been decreased while the number of beds available for long-term care has increased to reflect the demand within the service. There has been no change to the registration condition of the maximum number of residents accommodated at the centre.

The provider was aware of the requirement to notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
There is a system in place to review the quality and safety of care, and quality of life of residents. A system of audits is planned to include clinical data, environmental matters and document control management. Audits of the management of medicines, nutrition and the meal time experience, any accident or falls sustained by residents and care planning practices are on going.

The person in charge has completed a training programme led by the psychiatry team and the Health Service Executive (HSE) titled, Functional Interventional Training System (FITS). An audit on the use of psychotropic, anti anxiety and night sedative medicine was undertaken in October 2016 and January 2017 in connection with the psychiatry training program.

An annual report on the quality and safety of care was compiled. While the statistical data was complied, a summary to interpret the data was not completed with an action plan for improvement, developed for 2017. The outcomes of the most recent meal time, hygiene and risk audit were displayed on the wall of the corridor close to the entrance to the main sitting room. However, as required by regulation, the annual report was not made available to the residents or their representative for their information.

Judgment:
Substantially Compliant

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
There was a residents' guide developed containing all the information required by the regulations. This detailed the visiting arrangements, the term and conditions of occupancy and the complaints procedure.

All residents accommodated did not have an agreed written contract. Each resident accommodated for respite did not have an agreed contract with the service provider in place. One resident accommodated for long-term care since November 2016 did not

have a contract of care agreed.

All contracts did not have the total fee and the amount payable by the resident identified in schedule 5 as per clause 7.3 which stated, 'the fees payable are set out in schedule 5'.

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:
The centre was being managed by a qualified and experienced nurse. She has appropriate qualifications, sufficient practice and management experience to manage the residential centre and meet it stated purpose, aims and objectives.

The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience. She is supported in her role and responsibilities by a clinical nurse manager rostered five days each week.

She maintained her professional development and attended mandatory training required by the regulations. A valid and up to date registration with An Bord Altranais is agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) was available.

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

Findings:
There were effective and up to date safeguarding policies and procedures in place. Measures were in place to protect residents. The management team demonstrated their knowledge of the designated centre's policy.

Staff members had completed refresher training in the safeguarding of vulnerable adults in line with the introduction of a new safeguarding policy. The inspector found when speaking with members of staff that they understood how to recognise instances of abusive situations. They were aware of the appropriate reporting systems in place. Staff identified a senior manager as the person to whom they would report a suspected concern. Staff spoke confidently of being able to relay any issues and confirmed they are always listened to and their concerns are acted on.

Through observation and review of care plans staff demonstrated were knowledgeable of residents' needs. Staff provided support that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties.

There is a policy on the management of responsive behaviour. Staff could describe particular residents' daily routines very well. Some staff had received training in responsive behaviours and caring for older people with cognitive impairment or dementia. As outlined in the centre's statement of purpose 'the Sullivan Centre's sole purpose is the care of older people primarily over the age of 65 years, who are mobile and have a diagnosis of dementia'. Therefore all residents accommodated have a condition which will progressively impair their cognitive ability. Six staff from an agency who regularly work at the centre, some consistently for the past two years, were not trained in caring for older people with cognitive impairment or dementia. This was an area identified for improvement in the action plan of the previous inspection report.

In line with national policy a restraint free environment was promoted. Restraint management procedures (the use of bedrails, lap belts and security monitoring bracelet) were in place. At the time of this inspection there were no bedrails or lap belts in use. Capacity to make decisions and give consent in relation to residents wearing security monitoring bracelet has been undertaken. A complete review of the practice was undertaken since the last inspection. Risk assessments and a plan of care are developed to outline the need with consent obtained. At the time of this inspection there were no residents wearing a restrictive monitoring device.

Judgment:
Non Compliant - Moderate

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

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 risk management policy contained the procedures required by the regulation 26 and Schedule 5, to guide staff. The person responsible for the health and safety procedures and organisation's safety structure were included in the risk management policy.

Adequate fire safety precautions were in place. Staff had completed refresher training in fire safety. An external trainer visits the centre at intervals annually to train staff on fire safety. Further sessions were arranged for 2017.

Residents needs had been assessed to outline their evacuation requirements in the event of a fire occurring. Personal emergency evacuation plans were developed as required by the action plan of the previous inspection report. Four fire evacuation wedges were available to assist in evacuating residents with impaired mobility. These were located at the corner of each corridor.

There were arrangements in place for appropriate maintenance of fire safety systems such as the fire detection and alarm system. Fire safety equipment was serviced every three months and annually in accordance with fire safety standards. Fire exit signage was in place. Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed around the building.

There were procedures to undertake and record internal fire safety checks. Regular checks of the fire extinguishers were undertaken to ensure they were in place and release pins were intact, the fire panel and automatic door closers were operational. Records were maintained evidencing the fire escape routes were checked.

There were procedures in place for the prevention and control of infection. Hand gels were located along the corridor. Audits of the building were completed at intervals to ensure the centre was visibly clean. There were a sufficient number of cleaning staff rostered each day of the week. There was is a colour coded cleaning system to minimise the risk of cross contamination.

Training records evidenced that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents' needs. There were arrangements in place to review accidents and incidents within the centre. Falls risk assessments were completed and care plans were in place to minimise risk. Each resident's moving and handling needs were identified. These were available to all staff at the point of care delivery in bedrooms and outlined on a white

board in the nurses' office.

Hand testing indicated the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to windows. Access to work service areas to include the kitchen and sluice room was secured in the interest of safety to residents and visitors. Fire extinguishers while easily accessible to staff were secured to minimise risk of being tampered with.

There was one resident who smoked at the time of this inspection. A smoking risk assessment was completed to outline the supervision and assistance required. The resident did not hold cigarettes or lighters on their person following risk assessment at the time of this inspection.

Judgment:
Compliant

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:
Policies and procedures were in place to guide staff in the management of residents' medicine. They included information on the prescribing, administering, recording, safekeeping and disposal of unused or out of date medicines. Practices were satisfactory to ensure each resident was adequately protected by all medicine management procedures.

There were no residents self medicating at the time of this visit. Medicines are dispensed from individual packs.

The inspector reviewed a sample of drugs charts The prescription sheets reviewed were legible. Regular medicine, p.r.n medicines (a medicine only taken as the need arises) and short-term medicine were identified separately on the prescription sheets. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medicine. The maximum amount for p.r.n medicine was indicated on the prescription sheets examined.

The medicine administration sheets viewed were signed by the nurse following administration and recorded the name of the drug and time of administration. Medicines were administered within the prescribed timeframes. There was space to record when a medicine was refused on the administration sheet.

Medicines that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) regulations. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift.

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:
A comprehensive assessment of needs was completed for each resident on admission. Recognised 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, continence needs and mood and behaviour. Risk assessments were regularly revised.

There were care plans in place for each identified need. There were also specific care plans to meet the needs of the residents with impaired cognitive function. These were outlined in care plans to manage issues ranging from disturbed thought process secondary to dementia, altered emotional status and impaired communication due to dementia. In the sample of care plans reviewed there was evidence that care plans were updated at the required four monthly intervals or in a timely manner in response to a change in a resident's health condition. There was evidence of consultation with residents or their representative in all care plans reviewed of agreeing to their care plan.

There was a good emphasis on personal care and ensuring personal wishes and needs were met. Staff were knowledgeable of residents' preferred daily routine, their likes and dislikes. Personal profiles were developed in detail and displayed in frames in residents' bedrooms.

The systems to evaluate some care plans require review. In some cases care plans were reviewed mainly by signing and dating. The evaluations did not document or highlight changes or a professional judgment of the effectiveness of the care plan in place. A

conclusion of the effectiveness of the care pathway being followed was not indicated.

A social emergency admission was accepted by the centre to ensure the safety and wellbeing of the resident. While this was in line with the centre's statement of purpose, no future care plan had been developed to meet the resident's long-term care needs or to ensure the placement was best suited to their individual capacity and life stage. There was limited social worker support post admission.

Residents had good access to regular GP services. There was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. The GP's reviewed and reissued each resident's prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

There were no wound care problems being managed at the time of this inspection. A good range of pressure relieving equipment is available. Residents with poor skin integrity or fragile skin were provided with air mattresses.

There was one resident under the care of the palliative team. Each resident had a plan of care for end-of -life. The care plans contained details of personal or spiritual wishes, and resident's preferences regarding a hospital transfer if of a therapeutic benefit was documented.

Judgment:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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 building was well maintained, warm, comfortably decorated and visually clean. There are a number of different sitting rooms available to residents. The dining room is suitable in size to meet residents' needs and is located beside the kitchen. There are a number of smaller room residents can chose to occupy apart from the main sitting room area. Other facilitates include a visitors' room, oratory, and a conservatory sitting area.

Bedrooms accommodation comprises 21 single bedrooms. There was a call bell system in place at each resident's bed. Suitable lighting was provided and switches were within residents reach. There were a sufficient number of toilets, baths and showers provided for use by residents. Toilets were located close to day rooms for residents' convenience.

Clocks have been provided in all bedrooms since the last inspection as this was a matter identified for improvement to assist in orientation as regards time.

A safe enclosed garden provided with seating is available to residents.

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):
No actions were required from the previous inspection.

Findings:
The majority of the residents attended the dining room or day sitting room for their main meals. Residents were offered a varied, nutritious diet. The menu cycle was rotated every three weeks and facilitated the preferences of individual residents. There were picture menus available to outline all the options available for both lunch and evening tea. The picture menus were displayed on the table and written on a white board in the dining room.

There were sufficient numbers of staff on duty to offer assistance to residents in a discreet and sensitive manner. There was an emphasis on residents' maintaining their own independence. Meals were served in accordance with each resident's dietary requirements. Residents requiring a modified consistency had the same choice of options as all other residents. Cold drinks including juices and fresh drinking water were readily available throughout the day.

The centre's policy is all residents are to be weighed at a minimum once a month. Each resident had a nutritional care plan. Access to a speech and language therapist was available to obtain specialist advice to guide care practice. However, there was evidence of delayed referral to a dietitian. One resident who was extremely active and mobilised for lengthy periods due to a dementia related condition. The resident was reviewed by the GP and a plan to manage the issue was in place. However, there was a delay in referral to obtain specialist advice to guide care practice and help maximise a safe

nutritional status.

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

Findings:
The total care and support staff employed by the centre is 22.19 whole-time equivalent. This comprises of 7·75 registered nurses including the nurse management team and 13 care assistants. In addition, there is catering, cleaning, laundry and a diversional activity therapist employed.

There was an adequate complement of nursing and care staff on each work shift. The supervision arrangements and skill-mix of staff were suitable to meet the needs of residents, taking in account of the purpose and size of the designated centre. There are two nurses and a clinical nurse manager rostered over five days each week along with the person in charge. There is one nurse rostered each night. There are five care staff rostered throughout the morning until early afternoon. There are three care staff from 5.00pm until 11.00pm and two during the night.

A sample of staff files examined contained all matters required by Schedule 2 of the regulations. A record was maintained of staff nurses' current registration details with their professional body.

There was one volunteer working in the centre. Records specified by the regulations were available outlining the role and responsibilities, supervision arrangements and confirmation of Garda vetting.

There was a training matrix available which conveyed that staff had access to ongoing education and a range of training was provided. In addition to mandatory training required by the regulations staff had attended training on infection control, nutritional care, cardio pulmonary resuscitation techniques and end-of-life care. All nursing staff

were facilitated to advance their clinical skills and supported by management to engage in continuous professional development. However, as identified in Outcome 7, Safeguarding and Safety, six staff were not trained in caring for older people with cognitive impairment or dementia.
Judgment: 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:

PJ Wynne
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:	Sullivan Centre
Centre ID:	OSV-0000494
Date of inspection:	04/04/2017
Date of response:	05/05/2017

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:
While the statistical data was complied a summary to interpret the data was not completed with an action plan for improvement developed for 2017. The annual report was not made available to the residents or their representative for their information.

1. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation

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

23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
The summary has now been completed and a copy of the review has been made available to residents and their families.

Proposed Timescale:
Completed 30/4/2017

Proposed Timescale: 05/05/2017

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All residents accommodated did not have an agreed written contract.

2. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
Contracts are now in place for all residents already resident within the centre.

Proposed Timescale:
Completed 13/4/2017

Proposed Timescale: 05/05/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All contracts did not have the total fee and the amount payable by the resident identified in schedule 5 as per clause 7.3 which stated the fees payable are set out in schedule 5.

3. Action Required:
Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
The issue of charges not being stated within the contract arises where an admission has occurred for reasons of urgency or overriding need, either in the community or within another service where grave risk has been identified in relation to a vulnerable client. Currently to ensure a person's safety a resident may be admitted to a public unit as an urgent case without the relevant assessments and determinations in place.

Consultation is being undertaken with Senior Management around the options to address this anomaly. This may include the formulation of an Interim Contract pending finalising the resident's financial assessment and application of liability for fees. Alternatively, strict adherence to the current admission criteria may need to be re-established. Bed designation will form part of this discussion as we currently only have any beds assigned to Respite Care and Long Term Care .

Proposed Timescale: 30/09/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Six staff from an agency who regularly work at the centre, some consistently for the past two years, were not trained in caring for older people with cognitive impairment or dementia.

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

Please state the actions you have taken or are planning to take:
Consultation has taken place with the Agency and agreement has been reached on the provision of dementia training. All regular agency staff will be provided with training through the HSE NMPDU/CNME, subject to availability.

Proposed Timescale:
Three agency personnel will be attending the two day National Programme which will be completed by 4th Oct 2017. Further places will be allocated when further dates are made available (awaiting schedule from the NMPDU)

Proposed Timescale:

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 systems to evaluate some care plans require review. In some cases care plans were reviewed mainly by signing and dating. The evaluations did not document or highlight changes or a professional judgment of the effectiveness of the care plan in place.

5. 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:
Current documentation is being revised in order to ensure better clarity around care plan reviews.

Proposed Timescale: 31/08/2017

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A social emergency admission was accepted. No future plan of care had been developed for the resident to meet their long term care needs to ensure a placement best suited to their individual capacity and life stage. There was limited social worker support post admission.

6. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Referral to the Psychiatric Consultant for a Capacity Assessment has been made and we await this determination. Subsequent functional assessments are planned on foot of a positive outcome, with a view to a supported community discharge. It is envisaged that this resident may not require long term care in this environment. In the event of this option not materialising, it is the intent of the PIC and Nursing Management to seek a less restrictive placement for this resident. It is not possible to formulate a plan beyond these parameters until such time as the necessary assessments have been completed. The resident's expressed wish is to remain here in this interim period.

Proposed Timescale: 30/09/2017

Outcome 15: Food and Nutrition
Theme: Person-centred care and support **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** There was a delay in referral to obtain specialist advice to guide care practice and help maximise a safe nutritional status. **7. Action Required:** Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise. **Please state the actions you have taken or are planning to take:** Consultation with the Medical Officer was undertaken immediately in this case. A care plan addressing the weight loss was put in place when weight loss was first recorded and was being actioned accordingly. Outcomes were being monitored and the plan was under very regular review in ongoing consultation with the Medical Officer. Referral to the dietician was made as part of this process. Whilst this referral could have been made earlier than it was, the outcome of the assessments made by the dietician clearly demonstrated that our interventions and management of the weight loss was both effective and timely. The plan subsequently put in place by the dietician was to reduce the level of supplementary nutrition that we had been providing on the basis that it was surplus to the resident's requirements. Proposed Timescale: Completed
Proposed Timescale: 05/05/2017