

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Carysfort Nursing Home
Centre ID:	OSV-0000022
Centre address:	7 Arkendale Road, Glenageary, Co. Dublin.
Telephone number:	01 285 0780
Email address:	edwardpakenham@carysfortnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Breda Pakenham & Edward Pakenham Partnership, trading as Carysfort Nursing Home
Provider Nominee:	Edward Pakenham
Lead inspector:	Sheila McKeivitt
Support inspector(s):	Emma Cooke
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	51
Number of vacancies on the date of inspection:	0

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 09 August 2016 09:00 To: 09 August 2016 20:00

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

Summary of findings from this inspection

This was an unannounced inspection conducted by two inspectors over one day. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. In order to determine this inspectors focused on six outcomes and followed up on six outcomes from the last monitoring inspection which took place in November 2014. There were 51 residents in the centre and one resident in hospital on the day of inspection. 33 of the 51 residents in the centre had a diagnosis of cognitive impairment, alzheimers disease or dementia. The centre did not have a dementia specific unit.

Prior to this inspection the provider had submitted a completed self-assessment document to the Authority along with relevant policies and inspectors reviewed these documents prior to the inspection. The judgments in the self assessment stated four were in compliance and two in substantial compliance with the six outcomes.

Inspectors reviewed compliance with condition 8 on the certificate of registration. The provider and inspectors had a discussion about the wording and interpretation of condition 8.

Inspectors found the health and social care needs of residents with dementia were met. However, resident assessments, care plans and daily nursing progress records required improvement. There was a minimum use of restraint in use. Alternatives were trialed and tested prior to restraint being considered and records reviewed reflected this. However, staff management of behaviours that challenged required review to prevent escalation. The staffing levels were good however, the skill mix on night duty needed to be kept under constant review. Staff had received training to enable them to engage and care for residents who had dementia. However, further training was required around communication and interaction with residents with a dementia diagnosis. Some aspects of medication administration and prescription practices required review. Areas of the premises required review to ensure it enabled residents with dementia to flourish. Residents with dementia right to choice in relation to all aspects of their life required review. The management of complaints was robust.

The action plans at the end of this report reflect where improvements need to be made.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The wellbeing and welfare of residents with a diagnosis of dementia, alzheimers and those with cognitive impairments were being met. However, records including resident comprehensive assessments, individualised risk assessments, care plans and daily progress notes were either incomplete or lacked the detail required to reflect the resident's status.

There was a detailed admissions policy which was reflected in practice. The person in charge completed a pre-admission assessment on each resident. She had reviewed this form since completing the self assessment and added a section relating to the residents capacity. This was shown to inspectors.

Residents had access to medical and allied health care professionals of their choice. The centre had access to a consultant geriatrician and psychiatry of old age based in the local hospitals. There was no delay in referring residents for assessment to any of the allied health care team members. Inspectors saw evidence of referrals made, assessments completed and recommendations made in the 4 resident files reviewed.

All residents had chosen a general practitioner and pharmacist from practices close by to care for them. Two general practitioners were in the centre reviewing residents on the day of inspection and there was evidence that all residents had their medical needs including their medications reviewed on a regular basis.

Inspectors were informed that residents had comprehensive assessments completed on admission. However, these comprehensive assessments were found to be incomplete. For example, one resident was admitted in early July 2016, several areas of the comprehensive assessment section including the nutrition and sleep and rest section of the assessment were blank. Another resident admitted in April 2016 comprehensive assessment lacked detail for example, under breathing and circulation and sleep "normal" was written. This lack of detail did not provide a clear picture of the condition of the residents' on admission.

Inspectors reviewed risk assessments reflecting the resident's risk of developing

pressure ulcers, sustaining a fall, requiring a restraint and developing malnutrition to mention a sample. These were completed after the comprehensive assessment and on the whole were complete and were reviewed within a four month period.

Residents' needs identified on assessment did not all have a corresponding care plan in place reflecting the care required to meet the need. For example, one resident identified on assessment as being non verbal did not have a comprehensive care plan outlining how staff could communicate with this non verbal resident. This in turn resulted in staff not being able to communicate appropriately with this resident as observed in the dining room during lunch. There was no link between the progress notes written by staff nurses and the residents' care plan. The progress notes reviewed were vague they read: "in good form", "needs attended too", "good night" or "good day". They were not detailed enough to reflect the care provided to the resident on the day or night shift.

Staff provided end of life care to residents with the support of the general practitioner and the palliative care team if required. Each resident had their preferred resuscitation and preference regarding transfer to hospital detailed in their comprehensive assessment. However, other preferences such as funeral, burial, cremation were not included. Residents' who had an end of life care plan in place were not detailed enough to direct care. They included the same two pieces of information as recorded in the end of life assessment. They did not address the resident's physical, emotional, social and spiritual needs.

Residents who had been transferred into and out of hospital had copies of their transfer letter from the centre to the acute hospital on file together with nursing and medical transfer letters from the acute hospital back to the centre.

Residents' nutritional needs were met and there was evidence of good communication between the catering and nursing/care staff. The menu provided a choice of two meals at lunchtime. However, the menu was not displayed, accessible or visible to all residents'. There was a menu on one of the four tables in the main dining room and none on display in the upper dining room. Inspectors observed staff serving meals and noted all residents were not offered a choice at lunch time although a choice was available.

There were two meal sittings at lunch time. Residents who required support at mealtimes were provided with assistance from staff at the first sitting in the sitting room. This sitting included a number of residents' with dementia and inspectors observed that it was noisy, busy and cramped. Staff brought three meals at a time from the kitchen to be served. As the dining tables were positioned at either side of the doorway leading in and out of the dining which lead into the sitting room and conservatory room there was constant stream of people passing through as residents' were having their lunch. Hence, the environment was not conducive to having a quiet, calm peaceful lunch.

The centres medication management policy was available for review. Inspectors saw that controlled medications were locked in a secure cabinet within the locked nurses station. Medication storage trolleys were locked and chained to the wall in two communal areas. The person in charge informed inspectors there was no other area

where these could be stored. Medication administration observed on the day of inspection was not as per professional guidelines. The staff nurse observed administering medications to residents signed the medication administration chart prior to the resident taken the medication. Residents identified on assessment as requiring their medications to be administered in a crushed format were having them administered as crushed. However, they had not been prescribed as crushed on the residents prescription chart.

This outcome was judged to be substantially compliant in the self-assessment, the inspectors judged it as moderately non compliant.

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:

Measures to protect residents with dementia being harmed or suffering abuse were in place. Residents spoken with stated they felt safe in the centre. There was a policy and procedures in place for the prevention, detection and response to abuse which reflected the National Health Service Executive policy and procedures "Safeguarding Vulnerable Persons at Risk of Abuse" 2014. There had been no reported incidences from the centre since the last inspection.

Staff spoken with demonstrated a knowledge of what constituted abuse and had up-to-date refresher training in place. Staff did not manage any monies on behalf of the residents.

There was a policy which reflected the use of restraint in the centre. It referenced the National Policy 2011 "Towards a Restraint Free Environment" on the use of restraint. Practice observed reflected policy. Alternative equipment was available and used as a first resort and does trailed, tested without success were recorded in those small number of residents who had bedrails in use as a form of restraint. The person in charge completed a monthly audit of the small number of resident prescribed as required psychotropic medications. The quarterly returns showed that no resident had required them in the second quarter of 2016.

The policy in place reflected the care provided to manage behaviours that challenge. Residents who intermittently displayed behaviours that challenged had care plans in place. However, the care plans reviewed did not always reflect triggers for the resident's

behaviour, how to avoid them and diversional therapies to try. Resident's prescribed psychotropic medication on an as required basis to manage these behaviours did not have these reflected in their care plan. Inspectors observed one resident displaying behaviours which had a direct negative impact on another resident. Staff were slow to intervene and did not appear confident in how to intervene.

This outcome was judged to be compliant in the self-assessment, inspectors judged it as being moderately non compliant.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

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:

Residents with dementia were consulted with and participated in the organisation of the centre. Residents' privacy and dignity was respected, including receiving visitors in the quieter front reception area. There was a policy for staff on how to communicate with residents including those with dementia. However, as discussed under outcome 11, communication between staff and residents was not always to a good standard and notices with information for residents' such as activity timetables and choice at meal times was not always accessible to them. Also, residents were not given a choice at all times.

Residents were in the process of completing a quality satisfaction questionnaire which they had been issued with to gain feedback about the service they were receiving. Inspectors were informed that this information was going to be used to inform the annual review.

Inspectors were informed that the activities coordinator acted as an advocate for residents. Resident meetings were facilitated by the activities co-ordinator and minutes of these meetings were available for review. However, the records did not state if issues brought up at these meetings were addressed, by whom, when and/or if the outcome was feedback to residents at the next meeting. Therefore, it was not evident if issues brought up at these meetings were being addressed.

Residents' privacy was respected. They received personal care in the privacy of their own bedroom, their own bed space or in a bathroom which could be locked. All showers now had privacy screening in place.

Inspectors were informed all residents were registered to vote and a number of residents were facilitated to vote in the centre. Residents told inspectors' that Mass was said in the centre and some said their family took them out to Mass. Clergy from other religions were welcomed to visit residents in the centre. Inspectors saw residents' had access to the daily newspapers and they were seen reading these in two of the three sitting rooms on the morning of this inspection. Residents' had access to a private telephone and wifi was available throughout the centre.

There was a wide variety of activities available, including a number which met the needs of those with dementia. Inspectors noted the activity timetable although on display in the dining room, it was not visible to residents. Those spoken with were not aware of what activities were scheduled for the day. Hence, they were not enabled to plan their day independently of staff. Other aids to enable residents with a dementia to remain orientated to time, place and date were not available. There were no clocks, orientation boards or boards displaying any information of interest to residents such as minutes of their meetings, activity timetables or upcoming events of potential interest to them. However, the management team did state in the self assessment document (submitted on 20 July 2016) that clocks would be available within four weeks.

Records of activities provided were recorded in residents individual file was recorded however, records reviewed did not reflect their level of participation. Inspectors observed that when the activity co-ordinator was delivering activities in one of the three sitting rooms health care assistants were supervising residents' in the other two sitting rooms. The level of interaction and communication between health care assistants and residents at these times was minimum. It was task orientated and required improvement.

Inspectors observed lunch being served to residents' in two communal dining rooms. Inspectors observed staff communicating to residents with a dementia at lunch time. The tone used by some staff required improvement. Examples were given to the management at the feedback meeting at the end of this inspection. Also, staff were observed placing protective clothing on residents. Residents were not given a choice to wear these or not.

This outcome was judged to be compliant in the self-assessment, inspectors judged it as moderately non compliant.

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:

There was a complaints policy in place which met the regulatory requirements. A copy was on display in the front hallway.

Residents with dementia told inspectors that they would complain to the person in charge or any of the staff caring for them. A review of the complaints recorded over a two year period showed there were few complaints. These were dealt with promptly by the designated complaints officer (the person-in-charge), the outcome of the complaint and the level of satisfaction of the complainant were all recorded. There was an appeals process, however none on file had been appealed.

One of the two owners overviewed the complaints process ensuring they were all addressed as per the complaints policy.

This outcome was judged to be compliant in the self-assessment, inspectors also judged it as compliant.

Judgment:

Compliant

Outcome 05: Suitable Staffing**Theme:**

Workforce

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

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

Findings:

There was appropriate staff numbers and skill mix to meet the assessed needs of residents and for the size and layout of the centre. Since the last inspection 2 staff nurses were now rostered on duty until 10.30pm.

Records reflecting registration details of staff nurses for 2016 were available for review. Staff had up-to-date mandatory training in place. Inspectors saw evidence that staff had completed a variety of training on other areas of clinical practice such as first aid, hand hygiene, infection control, managing behaviours that challenge and caring for residents with dementia. However, as mentioned under outcome 16, the communication skills of a number of staff required improvement.

Staff nurses had completed training in medicines management and the person in charge had completed a competency assessment on medication management with each of the staff nurses within the past year. However, as mentioned under outcome 11, practice observed by inspectors was not inline with professional guidelines.

There was an actual and planned staff roster which reflected the staff on duty. Staff told inspectors that they had appraisals completed with the person in charge each year and they attended staff meetings. Supervision of staff in the mornings appeared good as there were 3 qualified staff, 11 health care assistants and 1 activity coordinator on duty. However, inspectors observed that there was no qualified staff member supervising lunch in the main dining room.

This outcome was judged to be compliant in the self-assessment, inspectors judged it as substantially compliant.

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 centre is located in a suburb south of Dublin city. It was built in the 1900's, has been in operation as a nursing home since 1959 and has been run by the current providers since 1989. A high proportion of the residents are from the area.

Condition 8 stated; room seven, a four bedded room located on the first floor shall be reduced to three beds and reconfigured to meet the resident needs. No new resident may be admitted to this room until the number of residents in the room is reduced and the physical environment reconfigured to meet resident needs. Inspectors were informed that a resident living in this bedroom had deceased since the current registration certificate was issued to the provider. An existing resident was moved from room 12 into room seven, hence four residents continued to live in room seven. The provider explained to inspectors that the resident was not a new resident but an existing resident therefore they were still operating within the conditions of operation.

The centre was spread over a number of floors. The centre did not have a lift. Residents access to the first, second and top floor was via a chair lift. A high number of the fifty one residents (33 of whom were identified as having dementia, alzheimer's or a cognitive impairment) required the assistance of at least one staff member to operate the chair lift. This restricted their ability to remain independent for as long as possible in the centre.

The providers were found to be operating in compliance with condition 9 of their conditions of registration; inspectors found that residents living in room six, 23, 24 and

25 were all independently mobile a number requiring supervision when using the stair lift. All were having a professional review by the physiotherapist once per month.

Residents occupying some of these shared rooms had a lack of individualised storage facilities. For example, inspectors saw residents in twin room 25 shared a wardrobe, each having been allocated one side of the wardrobe as their personal space. All residents in room seven did not have enough room by their bed for a bedside locker. There was a lack of floor space in these rooms to accommodate individualised pieces of furniture for each resident, which infringed on residents privacy and did not allow for free movement around all furniture.

Residents were encouraged to personalise their bedrooms and inspectors saw that most residents did so. Multiple occupancy bedrooms were situated close to bathrooms and toilets.

The centre was clean tidy, well light and heated. However, inspectors observed that room 24 situated on the top floor had no window. The single bedroom contained a velux window; one had to be standing up in order to see out of this velux window.

The two communal areas were large and decorated in a homely manner. They were situated on the ground floor, one of the two accessible via a slight incline. The larger of the two rooms had the dining room situated to the front of the room and lead via a seating/ television room into a large bright conservatory which in turn lead out to the rear garden and raised decked area, accessible to residents. The position of seating in both these rooms did not support social interaction as chairs were located around the perimeter of both rooms. The position of the dining area required review, this will be discussed further under outcome 11.

The corridors were wide. Inspectors observed they did not have handrails in place on either side. Residents were seen using the dado rail to balance themselves with. The bathrooms and toilets had grab rails in place. Non slip floor covering was used throughout the centre. The sanitary wear, wall tiles, flooring, handrails and toilet seat cover were all decorated in plain colours. Raised toilet seat frames had been painted a shade of pink and bright coloured toilet seat covers were used to enable those with dementia to remain independent when using their bathroom. Toilet and bathroom doors were in the process of being painted a shade of pink and those completed had contrasting bright pictorial signage in place. Inspectors were shown new bedroom door signs in place on some residents' bedroom doors that choose to use them. New bathroom and toilet door signage were also in the process of being installed. These new initiatives would enable residents' with dementia to maintain their independence for longer periods of time.

Residents had access to equipment required to meet their needs and inspectors saw that equipment such as pressure relieving mattresses, high-low beds, low low beds and hoists had been serviced within the past year. Inspectors observed two hoists were stored in resident bedrooms in the morning however; one of these was being stored in the linen room prior to lunch.

Records in relation to falls were reviewed and seen to contain all the required details including detailed follow-up completed by the person in charge.

This outcome was judged to be substantially compliant in the self-assessment, inspectors judged it as moderately non compliant.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors saw that the fire extinguishers were serviced on an annual basis and a service had been last completed in February 2016. The fire alarm was serviced on a quarterly basis and was last serviced in May 2016, the emergency lighting was serviced on a monthly basis by the provider. No faults in the emergency lighting system were noted however, the provider was not an authorised person to complete these checks. An actual fire drill was last practiced in November 2015. All staff spoken with were not clear on the actions to follow in the event of the fire alarm sounding. They acknowledged this was not practiced on a frequent basis. Inspectors were informed post this inspection that a fire drill was scheduled for 20 September 2016 and all staff had been requested to attend this training.

Judgment:

Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

While the provider was compliant under this outcome, inspectors saw that the number of residents residing in bedroom seven a four bedded room located on the first floor had not been reduced since the certificate of registration was issued in February 2015.

Condition 8 on the statement of purpose states that room seven a four bedded room, located on the first floor shall be reduced to three beds and reconfigured to meet resident needs. No new residents may be admitted to this room until the number of residents in the room is reduced and the physical environment reconfigured to meet their needs. The provider and inspectors had a discussion about the wording and interpretation of outcome 8. The provider told inspectors that one of the four residents residing in room seven at the time of the last inspection had died. Following this death another resident was moved into the vacant bed in room seven. The provider explained to inspectors that the resident was an existing resident in the nursing home who was occupying a different bed in a different bedroom and was not a new resident. The resident merely changed rooms. Four residents remained in room seven.

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:

Sheila McKeivitt
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:	Carysfort Nursing Home
Centre ID:	OSV-0000022
Date of inspection:	09/08/2016
Date of response:	11/10/2016

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:

Residents' did not have a comprehensive person centred care plan in place to reflect every identified need.

1. 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

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

that resident's admission to the designated centre.

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

Comprehensive person centred care plans are written on admission and reviewed every four months or sooner if required. Discussed about the importance of having a person centred care plan to direct care for each identified need of the resident, at the meeting conducted with the nurses since the inspection. Also discussed a few examples on how to write a proper person centred care plan to direct the care. The assistant Director of Nursing will conduct an audit of the care plans by the first week of November. Going forward the Assistant Director of Nursing will conduct a care plan audit the week following the admission of each resident and also four monthly. The Director of Nursing will review the audit results and discuss with the nurses.

Proposed Timescale: 30/10/2016

Theme:

Safe care and support

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

Residents comprehensive assessments were not fully completed on admission.

2. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

Pre-admission assessment is carried out by Director of Nursing prior to the admission of each resident. Upon the admission of a resident to the nursing home, a comprehensive assessment is done by the admitting nurse in conjunction with the resident and the family and also the information obtained from the pre admission assessment is used. A reassessment is done every four months or sooner if needed.

Since the inspection, a meeting was held with the nurses to discuss the gaps found in the comprehensive assessments. Nurses are asked to review the comprehensive assessment of their assigned residents by 15/10/2016. Director of Nursing will conduct a comprehensive assessment audit on 15/10/2016 to ensure that it is fully completed. Going forward the Assistant Director of Nursing will conduct this audit a week after each admission. This will be reviewed by the Director of Nursing.

Proposed Timescale: 15/10/2016

Theme:

Safe care and support

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

Residents' death and dying assessment and end of life care plan did not include the resident's physical, emotional, social and spiritual needs.

3. Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

All residents have an end of life care plan. On admission and on an on-going basis residents are asked for their preference regarding end of life care including their preference regarding hospital transfer and resuscitation. These are documented in their end of life care plan and are reviewed every four months or sooner if required. All staff had an end of life care training in August 2015. The meeting which was conducted with the nurses since the inspection highlighted the importance of comprehensive person centred end of life care plan which includes the resident's physical, emotional, social and spiritual needs. The Director of Nursing discussed a sample person centred end of life care plan with the nurses. All nurses are advised to review the end of life care plan of their residents. The assistant Director of Nursing will conduct an audit of end of life care plan by November first week.

Proposed Timescale: 30/10/2016

Theme:

Safe care and support

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

Residents were not offered a choice at lunchtime.

4. Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

Prior to inspection one menu was displayed in the dining room and the residents were asked for their choice of meals before the meal time. Since the day after the inspection, menu is displayed on all tables in both the dining rooms. A member of staff (floating staff) goes around the residents in the morning to collect their choice regarding lunch and delivers it to the chef. Residents are served their selected choice of meals at lunch time. The selected choice of meal is confirmed with the resident prior to serving the meals.

Proposed Timescale: 15/08/2016

Theme:

Safe care and support

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

The service of meals in the dining room required review.
Mealtime service was not supervised by a qualified member of staff.

5. Action Required:

Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

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

Prior to the inspection we had two sittings in the main dining room on the ground floor and one sitting on the first floor dining room. Since the inspection, a second sitting is arranged on the first floor dining room. A few residents from the first and the second sitting on the ground floor dining room are now brought to the second sitting on the first floor dining room. This facilitates more room for the residents who have their lunch on the ground floor dining room. Residents' choice regarding meal times are taken into consideration. Both sittings are always supervised by the nurse on duty. One nurse supervises the first sitting and the other nurse supervises the second sitting.

Proposed Timescale: 15/08/2016

Theme:

Safe care and support

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

The daily progress note written by staff nurses was not linked to the residents' care plan and did not reflect the care provided to the resident on the day or night shift.

6. 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:

We ensure that all residents receive care as per the care plan which is accessible to all staff. Since the inspection, staff nurses are advised and overseen to ensure that they write detailed day and night progress notes. Now the progress notes include a detailed daily report about each resident. This will be audited every four months by the assistant Director of Nursing and the audit result will be reviewed by the Director of Nursing.

Proposed Timescale: 20/09/2016

Outcome 02: 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:

Staff did not respond promptly to an incident of behaviour that impacted negatively on another resident.

7. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

All staff received dementia care and behaviours that challenge training in August 2015. This is updated every two years. The next training is scheduled for 17th and 19th of October. Staff are supervised by nurses at all times. One nurse supervises ground floor and the other two nurses are allocated to supervise first and second floor. Since the inspection all staff are asked to familiarise themselves with the resident's care plans which can be accessed via touch care. They are advised to read dementia care, behaviours that challenge and communication policy. All staff are reminded on a regular basis at the daily handover regarding the same and are informed about any changes in the resident's condition.

Proposed Timescale: 30/10/2016

Theme:

Safe care and support

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

The care plan of residents' identified as having behaviours that challenged did not include the details require to enable staff to manage the behaviours displayed in a prompt and safe manner.

8. 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:

A care plan is written on admission for each resident in conjunction with the resident and the family and this is reviewed every four months or sooner if needed. All Healthcare assistants are advised to refer to care plans which can be accessed via touch care. Any changes are discussed at the daily handover. At a meeting conducted post inspection, the nurses are asked to review the care plans of their residents mainly for the residents who display behaviours that challenge. A detailed person centred care plan will enable the staff to manage such behaviours in a prompt and safe manner. This will be audited by the assistant Director of Nursing by the first week of November and

the results will be reviewed by the Director of Nursing.

Proposed Timescale: 30/10/2016

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:

Information of interest to all residents' including those with a dementia was not accessible to them such as:

- Daily activities including times scheduled
- Choice of meals available at each mealtime
- Minutes of resident meetings
- Orientation tools

9. Action Required:

Under Regulation 09(3)(c)(i) you are required to: Ensure that each resident has access to information about current affairs and local matters.

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

Since the inspection, bulletin boards are put up (one on ground floor sitting room and one on first floor sitting room) to display information regarding daily activity timetable, upcoming events, day, date, minutes of meetings and any other information that would be of interest to the residents. The bulletin board is accessible to all our residents. The activity staff/ floating staff writes the stated information on the bulletin board every morning. The activity staff informs the minutes of the residents meeting to the residents. Menu is displayed on all tables in both the dining rooms. The menu font size has been increased and is changed from A5 to A4 size which enables the residents to read clearly.

Proposed Timescale: 13/08/2016

Theme:

Person-centred care and support

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

Staff did not always give residents a choice.

10. 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:

All staff have undergone person centred care training in July 2016 at the nursing home. Residents are always given choice regarding the care provided. Eg: Prior to the mealtime residents are asked for their choice of using protective clothing and are given an opportunity to select their preferred protective clothing. Since the inspection, staff are reminded on a regular basis, mainly at the daily handover regarding the importance of giving residents a choice at all times.

Proposed Timescale: 20/08/2016

Theme:

Person-centred care and support

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

Staffs communication skills were not in line with best practice.

11. 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:

All staff have undergone person centred care training in July 2016. Staff are polite and courteous to the residents. They are reminded on a regular basis and during performance review regarding the importance of the same. At the meeting conducted post inspection this was once again brought to the attention of all staff. Staff are advised to read the communication policy once again to develop their communication skills especially with residents with dementia. Healthcare assistants are supervised by staff nurses.

Proposed Timescale: 20/08/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Health care assistants were identified as requiring further training on how to communicate with residents with a dementia.
Staff nurses required further training in medicine management to ensure they adhere to professional guidelines.

12. Action Required:

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

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

All staff have undergone training on person centred care in July 2016, dementia care and behaviours that challenge in August 2015. The next dementia care and behaviours that challenge training is scheduled for 17th and 19th October. All staff nurses had the medication management training in May 2016. The Person in charge conducted medication management competency assessment in July 2016 and performance review for nurses on medication management in June 2016. Since the inspection all staff nurses are asked to strictly follow the medication management policy of the nursing home. Staff nurses are asked to undergo the medication management training on HSE land by the end of October. A medication management competency assessment was conducted once again post inspection in September 2016. The pharmacist conducts the medication management audit on a four monthly basis and the results will be reviewed by the Director of Nursing.

Proposed Timescale: 30/10/2016

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:

The following issues were identified with the premises;

There were no handrails on either side of corridors.

There was a lack of private storage space in some multiple occupancy rooms.

There was a lack of personal space in some multiple occupancy rooms.

There was a lack of storage space for equipment within the centre.

The resident in room 24 could not see outside the velux window from a sitting position.

4 residents continued to occupy room seven.

13. 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:

We have ensured that a chairlift connects all floors. We have placed a handrail on the dedo rail. We have ensured the provision of private storage in all bedrooms, whether shared, single and multi-occupancy. All residents have lockable lockers in room 7 in line with our engagement with HIQA inspectors prior to our re-registration and as per our agreement with those inspectors the shared wardrobe in room 25 is divided with a partition. All bedroom space in the Nursing Home is in line with Paragraph 1A of Schedule 6 of the Regulations. All residents are actively encouraged to personalise their bedrooms/living space and we have received ongoing feedback from our residents, including all our residents in the multi-occupancy rooms that they are very happy in their rooms which they view as spacious, bright, airy and clean. We have procedures in place to ensure that all equipment is stored away correctly after use.

We are in compliance with condition 8. A new window will be put in Room 24 so that

the resident can see out from a sitting position.

Proposed Timescale: Handrails were completed on 20/08/2016. Room 24 to be completed by 31/07/2017.

Proposed Timescale: 31/07/2017

Outcome 07: 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:

Staff were not clear on the actions to take in the event of a fire occurring in the centre.

14. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

All staff have had fire training with an external provider on the 8th and 15th September 2016. Could you please provide us with the names of the staff that were not clear on the actions to take in the event of a fire occurring in the centre as we would like to provide further training for these staff.

Proposed Timescale: 15/09/2016

Theme:

Safe care and support

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

The emergency lighting was not being serviced by an appropriately qualified person.

15. Action Required:

Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for testing fire equipment.

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

The emergency lighting was serviced on 05/09/2016 by a qualified person and will be serviced every three months.

Proposed Timescale: 05/09/2016