

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Shannagh Bay Nursing Home
Centre ID:	OSV-0000095
Centre address:	2-3 Fitzwilliam Terrace, Strand Road, Bray, Wicklow.
Telephone number:	01 286 2329
Email address:	info@shannaghbay.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Shannagh Bay Healthcare Limited
Provider Nominee:	Pauline Smith
Lead inspector:	Nuala Rafferty
Support inspector(s):	Deirdre Byrne
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	35
Number of vacancies on the date of inspection:	8

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.

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

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

The inspection took place over the following dates and times

From: 04 May 2016 10:00 To: 04 May 2016 19:00

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	Substantially Compliant	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures		Non Compliant - Moderate
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered progress on findings related to the premises following the last inspection carried out on 6 July 2015 and to monitor progress on the actions required arising from that inspection. The inspection also considered information received by HIQA in the form of notifications and other relevant information. The provider had completed a self-assessment tool on dementia care in 2016 and had assessed the compliance level of the centre as substantially compliant for all outcomes with the exception of the complaints procedures which was included in the self assessment tool sent to the provider. However, the findings of inspectors did not accord with the provider's judgments.

Inspectors found a good standard of nursing care was delivered to residents in an atmosphere of respect and cordiality. Safe and appropriate levels of supervision were in place to maintain residents' safety in a low key unobtrusive manner during this inspection. But improvements to some aspects of safeguarding were found to be required in that all staff were not trained in safeguarding vulnerable adults and prevention of abuse policies; appropriate and full investigations were not conducted into complaints made by some residents in relation to care delivery and capacity for decision making was not assessed where decisions on end of life interventions were in place.

The Action Plan at the end of this report identifies other areas where improvements are required to comply 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. These also include improvements to premises, activities, medication management and care planning processes.

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence that the well being and welfare of residents were being maintained through the provision of a good standard of nursing medical and social care.

Residents had access to GP services. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services.

Evidence of access to medical and allied health professionals was found with documented visits, assessments and recommendations by dietician speech and language therapists, physiotherapy and occupational therapist reviews.

Samples of clinical documentation including nursing and medical records were reviewed; these showed that all recent admissions to the centre were assessed prior to admission. The pre admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident.

The arrangements to meet residents' assessed needs were set out in individual care plans and each resident had a care plan completed. A number of assessment tools to check for risk of deterioration were used including; risk of falls, nutritional status, levels of cognitive impairment, skin integrity, pain, continence and communication. But not all of the assessments were fully completed and so could not be relied upon as an accurate determination of the level of clinical risk to resident's health. Examples included; social needs and preferences and cognition assessments. It was also noted that re assessments of falls risks following falls were not routinely carried out.

A number of care plans referred to family involvement in the care planning process, where family were consulted for decision making or to seek and give information relating to the resident. Inspectors were told that where residents attended clinic appointments they were usually accompanied by a member of staff, relative or other responsible person. This helped to ensure transfer of information back to staff in the centre. Results of investigations and discharge information from acute hospitals were available within residents' files.

A healthcare plan for every identified health or social care problem is required to be put

in place by the nursing team to maintain residents' health and well being and monitor improvements or deterioration. However, it was found that care plans were not in place for all identified needs. Examples of healthcare needs, where care plans were not in place included bruising or vomiting.

A strong system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health was not in place. The checks in place, although regular, did not consider the effectiveness of the plans to make sure they were detailed enough to maintain or improve a resident's health. It was also found that most although not all care plans were generic in nature and were not person centred.

Where care plans were in place they were not specific enough to guide staff and manage the needs identified examples included;

- Positive behaviour support plans were not in place to manage behaviours associated with restlessness and agitation. Some of the care plans in place did not fully guide staff on the signs to look for as potential triggers to responsive behaviour. These plans also did not guide staff on the type of distraction techniques which could be employed to reduce escalation or of all measures which were known to manage the behaviour and prevent recurrence. Documentation available and viewed did not give an accurate and full picture of the effectiveness of measures used to manage behaviours to inform future care planning and improve the residents overall health and well being.

- Medications used on an as required basis (PRN) to manage the behaviours were not referenced in the care plans and a separate care plan for medication management was not in place. It was noted that for some residents a number of different PRN medications were prescribed.

- Care plans in place to manage risks of falls did not guide staff on the potential causes of the falls or measures identified to reduce or prevent future falls. The plans did not include the recommendations of the physiotherapist regarding exercise regimes and the level of assistance required to implement them.

- A system to assess the capacity of residents with a formal or suspected diagnosis of dementia or other cognitive impairment to make decisions was in place. But improvements on the process to determine resident's capacity to understand complex issues and make informed decisions were required.

Not for resuscitation forms were in place for a number of residents. Where these were in place they were signed by the resident's general practitioner only. Although it was documented that the decision was discussed with the resident's family it was not always evident who had the discussion with the next of kin or when. On the sample of forms viewed it was noted that for most residents, the determination of capacity did not include the resident. On all viewed with the exception of one, the approach did not support the resident to be involved. For example several forms referenced that communication with the resident did not take place due to cognitive impairment. Where a full and frank discussion with one resident was documented the residents' signature was not on the form. Evidence that resident's were supported with help to identify their will and preference in these decisions was not found.

The difficulties staff and general practitioner's face in assessing capacity and the degree of sensitivity is acknowledged by inspectors who advised the team that their practice should be reflective of the Assisted Decision Making Capacity Act 2015 due to be enacted.

Menus were available and all residents were offered choice at each meal. The inspectors observed residents having their lunch in the dining room, where a choice of meals was offered. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. Assistance was discreet good humoured and punctuated with lots of smiles. Independence was promoted and residents were encouraged to eat their meal at their own pace by themselves with minimal assistance to improve and maintain their functional capacity. But interactions observed between staff and those residents with higher levels of need was task orientated rather than positive. Conversations were instructive rather than meaningful and there were several occasions where staff conversed with each other rather than the resident they were assisting.

As stated, menus were available and residents' were offered choice of meals. But inspectors found that an up to date diet list identifying those resident's with special dietary needs such as, diabetic; high calorie or high protein was not provided to the chef. Inspectors learned that the chef on duty on the day of inspection was not the regular chef but was covering an absence and was not familiar with all the residents' dietary needs.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Nursing staff were observed administering medicines to residents and follow appropriate administration practices.

It was noted that staff were familiar with each resident's medication and facilitated residents to take their medication at the prescribed time as part of their daily routine. On review of a sample number of the prescription and administration sheets inspectors identified a number of issues that did not conform with appropriate medication management practices including:

- The maximum daily dosage for p.r.n. (as required) medicines was not consistently indicated on the prescription sheet.
- The indication for use of p.r.n. (as required) medicines was not consistently documented on prescription sheets and sufficient specific guidance for staff in the administration of these medicines was not available.
- An error in the documentation of administration a p.r.n. medicine was found to have occurred. Inspectors noted that on three occasions the dosage of an anxiolytic medicine recorded as given differed from the dosage prescribed. However, it was noted that the drug provided to the centre by the pharmacist was the correct dosage prescribed and stock balances were not reported as being incorrect.

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 including policies to protect residents from being harmed or suffering abuse were in place and residents spoken with confirmed they felt safe and some knew who they would speak too if they were concerned. But the policy in place did not reference the revised National Policy on Safeguarding Vulnerable Adults 2014

Some staff spoken to by the inspectors confirmed that they had received recent training on recognising abuse, and were familiar with the reporting structures in place, but it was found that not all staff had received training and two complaints made by residents during 2015 were suggestive of abuse. There were systems in place to ensure allegations of abuse were fully investigated, however it was found that these were not fully implemented.

Both complaints concerned interactions between residents and staff. A complaint documented in July 2015 was made by a resident who alleged a staff member shouted and screamed at him. In December another resident alleged staff on day shifts refused to provide them with a shower repeatedly for a number of months. In both instances, the outcomes were recorded as satisfactorily resolved but there was no evidence that a detailed investigation was conducted into the allegations to determine if there were reasonable grounds for concern.

Evidence that these allegations were taken seriously or that the safety and well being of the residents involved were prioritised was not found. This was discussed fully with the provider who acknowledged that an investigation did not take place and that measures to address culture and practices within the centre, to prevent recurrence were not initiated.

This is further referenced under Outcome 4 Complaints.

The inspectors reviewed the system in place to manage residents' money and found that reasonable measures were in place and implemented to ensure resident's finances were fully safeguarded.

Improvements related to the determination of resident's capacity to understand complex issues and make informed decisions were required. These are detailed under outcome 1 Healthcare.

There were arrangements in place to review accidents and incidents within the centre, although all residents who had fallen did not have falls risk assessments completed after the falls or care plans were updated. This is also referenced under Outcome 1.

It was noted that there was a move towards changing the culture and promoting a restraint free environment. The use of bed rail restraint had reduced since the last inspection and the use of alternative measures such as low-low beds, mat and bed alarms had increased.

Judgment:

Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

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

Findings:

Evidence was found that resident's rights, privacy and dignity was respected during personal care delivered in their own bedroom or in bathrooms with privacy locks and the right to receive visitors in private. There were no restrictions to visiting in the centre and some residents were observed spending time with family or friends reading newspapers or chatting in the sitting room which was bright and spacious.

Choice was respected and residents were asked if they wished to attend Mass or exercise programmes. Some control over their daily life was also facilitated in terms of whether they wished to stay in their room or spend time with others in the communal rooms. But some residents told inspectors that choice related to times of rising /returning to bed was mostly determined by staffing and work considerations rather than their personal choice.

Inspectors were told voting in national referenda and elections were facilitated with residents polling cards being received but as the centre is not registered to enable polling few residents could exercise their right to vote.

Evidence that residents and relatives were involved and included in decisions about the life of the centre was viewed. A meeting was held regularly where residents were included in discussions on aspects of life in the centre. Discussions on aspects such as upcoming events, outings, menu changes and activity programmes formed the basis of the meetings. Although suggestions were sought and made by the residents' , minutes viewed did not include reference to any actions taken to implement the suggestions previously made.

The sitting room where the majority of residents spend their day was supervised and apart from short periods at least one staff member was present to ensure resident safety. An activity programme that included activities arranged for the mornings and afternoons such as; music, quizzes, bingo, card games, exercises, reminiscence and relaxation therapies. On the day of inspection, there was an exercise class and music quiz, hand massage and newspaper readings facilitated.

Inspectors found that all activities in the weekly programme were delivered in group sessions. Two activity coordinators, one per day were rostered to deliver the programme from Monday-Sunday. Although care and nursing staff engaged to some extent with activities it was noted that this involvement was mainly singing along to background music, engaging residents in conversation or when relieving the activity coordinator for lunch breaks. Inspectors found that the provider was committed to ensuring a good level of internal activity and stimulation for residents. On the day of inspection one member of the activity team was unavailable for work and the provider immediately arranged a replacement. It was also noted that no resident remained in bed or within their bedroom throughout the day. All were encouraged to get up each day and all were brought to the sitting room, dining area or conservatory even for a short period to give a change of scene and interaction with other residents, staff or visitors.

But the programme was not linked to residents' former interests or pastimes. It was also found that opportunities for residents to avail of external outings were very limited.

External outings did not form part of the core activity programme and inspectors were told that residents relied on their families to take them out. The last organised outing took place last summer. Although it was acknowledged by inspectors that outings are more limited in inclement weather, in conversation with staff and the provider it was found that social trips to the shops cinema or for coffee were not facilitated. Encouragement was given to family and friends to bring residents on small trips out to the local community, and inspectors were told that staff would frequently take residents out for walks on the promenade but organised outings to events such as theatres, shows or musicals were not arranged by the provider for residents.

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:
A policy and procedure was in place for the management of complaints. The procedure was on display. But the procedure displayed did not fully reflect the policy in place in that it did not refer to access to an independent mediator such as the Ombudsman or direct complainants of their right to contact HIQA of any concerns they may have. On review of the record of complaints there was evidence that some complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes but it was not clear whether a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved. It was also found that two complaints made by residents during 2015 were suggestive of abuse and were not investigated to establish if there was reasonable cause for concern. This is detailed under Outcome 2 safeguarding.

Judgment:
Non Compliant - Moderate

Outcome 05: Suitable Staffing

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

The number and skill-mix of staff was found to be sufficient to meet the needs of the current resident profile at the time of inspection.

Although a formal bank of relief staff was not in place, regular staff were called for availability to maintain consistency of care. The staff rota was checked, and found to be maintained with a legend identifying the shifts worked by different staff grades. But the names of all staff that worked in the centre were not fully identified. Staff were identified by first names only and staff on work experience were not included in the rota. Also the hours worked by the provider, person in charge or the General Manager were not included. It was also noted that the 24 hour clock was not in use although this is recommended best practice by the Irish Nursing Board for clarity.

Training records were reviewed and evidenced that staff had been provided with opportunities to attend required mandatory training such as fire safety, moving and handling, safeguarding and prevention of abuse. Additional clinical training in areas such as infection prevention and control; dementia care; management of behaviour that challenges and medication management was also provided.

Inspectors reviewed a sample of staff files and found that all of the required documentation was not in place in line with the requirements of Schedule 2 of the Regulations. Evidence that recently recruited staff had been vetted by the Garda Síochána was not available although inspectors acknowledge that there are current difficulties with this process where changes are being made by the National Vetting office. Evidence that references had been received, reviewed or checked was not available and for one staff person a personnel file containing any form of documentation was not available.

Judgment:

Non Compliant - Moderate

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:

Actions required further to previous inspections including the last registration inspection with regard to improving the premises to meet the requirements of the Standards were partially addressed.

Actions addressed included;

-Ongoing programme of maintenance and painting.

-premises upgrades with replacement of flooring lighting and furnishings also ongoing. The centre was found to be well maintained, warm, comfortably and tastefully furnished and visually clean. All walkways were clear and uncluttered to ensure resident safety when mobilising.

There were 14 single bedrooms, 13 twin rooms and one three- bedded room. All of the bedrooms contained en-suites, the majority were toilet only with some full shower en-suites. All of the bedrooms were personalised to reflect residents' individual wishes with pictures photograph's and mementos. There were separate assisted toilets showers or baths available on each floor.

A small quiet room or visitor's room was situated beside the main reception area on the lower ground floor. The dining room was also on this floor. The remaining communal areas consisted of a large sitting room extending the full length of the building and a bright and sunny conservatory area, both of which were located on the first floor. There were no communal areas on the ground or second floors.

However, plans previously notified to HIQA to commence building works in November 2015 to extend or renovate the premises to ensure compliance with Schedule 6 of the regulations had not been implemented. The provider was unable to give an approximate future date for this work but did say that the architects were again reviewing the plans to seek a better layout.

Plans for a raised internal garden to the rear of the centre for residents to enjoy were also in the planning stage.

Improvements to make the centre more easily accessible to residents with dementia were required. Signage with lettering or pictures were in place on some but not all toilet doors and were not in place on bedroom or bathroom doors. Colour schemes although a muted, primarily off white throughout did not include contrasting colours on toilet seats or doors to aid recognition.

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:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
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Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Shannagh Bay Nursing Home
Centre ID:	OSV-0000095
Date of inspection:	04/05/2016
Date of response:	17/06/2016

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:

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage identified needs.

Complete comprehensive assessments were not carried out for each resident in respect of every identified need.

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

1. Action Required:

Under Regulation 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:

Each resident is fully assessed prior to admission, to ensure Shannagh Bay can provide the care required. Where possible the potential new resident is encouraged to visit the nursing home prior to admission, if it is not possible for the resident to visit their family are invited to visit – they are encouraged to make an appointment for this visit to ensure the PIC has adequate time to spend with the resident/ family and answer to all their questions. – currently in place

Each resident when admitted is again fully assessed, initially the following assessments are completed;

- ◇ Braden
- ◇ Barthel Index 2
- ◇ MUST
- ◇ Comprehensive Assessment (Shannagh Bay)
- ◇ Stratify Falls Assessment
- ◇ PEEP
- ◇ MMSE Revised
- ◇ Moving and Handling
- ◇ Activity Assessments and Activity Plan
- ◇ Resident Individual Risk Assessment (revised)

Following the above assessments other assessments may be identified as being required – every effort is taken to complete the above assessments within 48 hours of admission.

Every effort is also taken to include the resident and/or their family at every stage in the admission procedure – currently in place

Once the above assessments are completed the care plans are commenced, again every effort is taken to include the resident in all aspects of planning their care – where the resident is unable to take part in the planning, the family are encouraged to take part. – currently in place

All residents who present with restlessness and /or agitation will have a functional assessment completed. Following this assessment a Positive Behavioural Support Plan will be put in place if required

All healthcare needs identified, now have either an individual plan of care or are included in an established care plan i.e. bruising is to be included in skin care, vomiting is to be included in the nutrition care plan. - completed

Each resident who requires a Falls Prevention Care plans will have their plan reviewed to include causes of falls and input from the physiotherapist.

The framework for care plans needs to be generic in form to ensure all aspects of care

are covered – but each individual resident will have specific input relating to their specific needs in each plan – an example would be the Dementia Care Plan which has 5 sub-headings that are generic:

1. Best possible physical well-being;
2. Meaningful relationships;
3. Future is valued and supported;
4. The resident is accepted and understood as an individual;
5. The resident is involved in life;

Each of these sub-headings is then developed with each individual resident and a specific plan is put in place to suit the individual resident's needs

All staff have been reminded of the importance of positive interaction with the residents of all levels of need and this will be reiterated each day during shift hand-over – occasionally some conversations need to be instructive rather than meaningful due to the resident's condition - some residents may not remember to swallow their food and need to be gently reminded.

An up-to-date list of each resident's nutritional requirements is now available in the kitchen and all staff are aware of any special requirements for each resident. - completed

A comprehensive system is currently being put in place to audit the effectiveness of the care plans and to ensure they reflect both the care being given and the care required.

Following this inspection an audit was carried out on the assessments and it was found that 11 Comprehensive assessments were not fully complete – this has since been completed

Proposed Timescale: 15/07/2016

Theme:

Safe care and support

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

Evidence that all care plans were fully reviewed for effectiveness as residents' needs changed was not found.

2. 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:

All care plans are reviewed every four months and sooner if there are changes in the residents condition – where possible this is completed with input from the resident and/ or their families

Individual Staff nurses have been allocated specific residents to ensure the care plans are reviewed as required and this process will be audited by CNM /PIC. Each resident is also being allocated a key HCA, who will assist the Nurse during the Care Planning process to further enhance each residents individual care plan.

At the staff nurse meeting held on 24th may 2016 (Minutes attached) the importance of accurate documentation was once again discussed and all nurses were reminded of their responsibilities in this matter. Particular attention is to be given to re-assessing each resident post all incidents, changes in condition and progression of illness, this information is to be accurately documented and information is to be passed on to all staff at twice daily handover meetings.

A comprehensive system is currently being put in place to audit the effectiveness of the care plans and to ensure they reflect both the care being given and the care required.

Proposed Timescale: 15/07/2016

Theme:

Safe care and support

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

Resident's were not supported to be part of the process in place to assess their decision making capacity. The assessment of ability to give consent to level of care interventions at end of life stage did not include every resident for whom a decision had been made. Evidence that their consent or will and preference had been sought was not available.

3. 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:

A review of the Do Not Attempt Cardiopulmonary Resuscitation Form is to take place in conjunction with a number of GPs. The revised forms will include the following details;

- ◇ Resident's name and date of birth
- ◇ Date of DNAR order
- ◇ Details on determination of capacity
- ◇ If the resident is deemed to lack the capacity – details and date of the discussion with the next of kin.
- ◇ Clinical issues and expected outcome if resuscitation were to take place
- ◇ Details of multidisciplinary team involved in the decision
- ◇ Signature of GP
- ◇ Review date for order

Proposed Timescale: 15/07/2016

Theme:

Safe care and support

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

Prescribing practices and supporting guidance on the appropriate use of all medications were not sufficiently specific to guide nursing staff to ensure the safe administration of all medication.

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:

Each nurse has been asked to complete a medication competency assessment and each nurse will be given detailed feedback on their results (please see copy attached)

At the nurses meeting mentioned above, medication was discussed in detail and the importance of accurate documentation was emphasised once again

Shannagh Bay Medication Management Policy is currently being reviewed with the nurses input and the revised policy will be discussed at the next nurses meeting scheduled to take place on 21st June 2016

All nurses have been asked to read;

-Medicines Management Guidance – HIQA

-Standards for Medicines Management for Nurses and Midwives – Draft Document, Bord Altranais agus Cnáimhseachais na hÉireann

-Each nurse has also been asked to complete the HSEland training on medication management

•The maximum daily dose for all p.r.n. medications is now clearly documented on the prescription sheet for each resident and the indication for its use. The error in the documentation of administration of a p.r.n. medication has been discussed with all the nurses and the importance of accurate documentation has been emphasised

•Auditing will be carried out regularly to ensure safe administering practices are followed at all times.

Proposed Timescale: 15/07/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

The policy in place did not reference the revised National policy on Safeguarding Vulnerable Adults 2014

5. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

Shannagh Bay Policies; Protection of Residents from Abuse & Responding to Allegations of Abuse have been reviewed and now references the revised National policy on Safeguarding Vulnerable Adults 2014. A copy of this was attached to the policy and is in the staff room for all employees to read. The CNM has completed policy training with all employees on Protection of Residents from Abuse & Responding to Allegations of Abuse. All policies are reviewed within a two year period or sooner if required.

Proposed Timescale: Completed

Proposed Timescale: 17/06/2016

Theme:

Safe care and support

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

All reasonable measures were not in place to ensure residents' were fully protected against abuse.

Complaints made by residents regarding staff interactions and provision of care to meet their needs were not appropriately or fully investigated by the provider or PIC as allegations of abuse. Measures to prevent recurrence were not identified or implemented

6. Action Required:

Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.

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

All complaints are taken very seriously and residents are supported and encouraged to voice their concerns in relation to any aspect of their care

Where a complaint is made the PIC follows our policy on complaints. All information is recorded in our nursing system software. Since the inspection we have upgraded our nursing system. The complaints section of this has become more detailed and there are more steps involved in the complaints process. This will guide the complaints procedure

and make it more robust. We are now using this new system for any complaints received – COMPLETED

We having a series of meetings with HCAs to discuss the complaints that have been received. This will enable us to inform all staff about the nature and the severity of the complaints. It will be pointed out that these complaints are considered to be allegations of abuse and should further occurrences be identified there will be notifications to HIQA and investigations will be carried out. The outcomes may lead to disciplinary actions been taken also – to be completed by 01/07/2016

At the meeting it will be discussed how staff should communicate with residents – from the words used, to tone of voice to body language. It will be outlined what is acceptable and unacceptable methods and behaviours – to be completed by 01/07/2016

The meeting will also outline to staff what to do if a resident makes a challenging request and how to deal with the situation so that the staff do not argue with the resident. In these situations the employee will be informed to excuse themselves politely and go to the CNM /PIC for assistance. – to be completed by 01/07/2016

Staff will also be advised what to do if they become frustrated or feel under pressure for reasons such as personal issues, tiredness, work load, so that we can prevent any unintended adverse actions towards residents – to be completed by 01/07/2016

Issues raised in the past and future issues will now be included in Elder Abuse training that takes place every two years for each employee. Where the case arises employees may need to attend training more often. Training slides will be updated and this will be completed by 01/07/2016.

The PIC/CNM will speak with the residents who have previously made a complaint to discuss if there has been any reoccurrences. The residents will also be informed of our new procedures and again welcome them to speak directly with management should they wish to make a complaint in the future - COMPLETED

The CNMs (where the CNM is not available the PIC will complete) will monitor the HCAs during morning care and ask who has had showers, baths and bed baths. The CNMs will subtly inspect residents to make sure they have been assisted to the high standards. Where standards are not met, the HCA will be spoken to, and if necessary will have a performance review – COMPLETED and on-going

All HCAs will be assessed by the CNMs to ensure they are following our policies and procedures and that they are meeting the required standards when it comes to assisting residents with activities of daily living. Where a HCA is not competent, the CNM will complete training with the HCA and a reassessment will occur within a specific time frame. All new employees will also be assessed using the same assessment forms within a month of their start date – Assessments (and reassessments) to be completed by 31-08-2016 and on-going

The agenda for the residents monthly meetings will now include "Previous/Current

Issues that have arisen as a Complaint". The issues will be mentioned and residents will be asked if they have witnessed these. Residents will be given an opportunity to discuss these in private if they do not wish to discuss in a group setting. This will be completed by the activity co coordinator and the minutes will be discussed and handed over to the PIC, who will action any feedback if required – agenda updated – COMPLETED

All HCAs are responsible for documenting everything they assist the resident with in our nursing system. This is audited by the PIC on a monthly basis. Where there are gaps these will be investigated and outcomes will be acknowledged. Where the employee is at fault the PIC will be spoken to and if required a performance review will take place. – on-going

•Training on the below policies have been identified:

-Total Patient Care – COMPLETED

-Protection of Residents and Responding to allegations of Elder Abuse – COMPLETED

-Quality of Life – COMPLETED

-Privacy, Dignity and Respect of Residents – COMPLETED

-Communication – to be completed by 01/07/2016

-Complaints – to be completed by 01/07/2016

-Skin Integrity and Pressure Area Care – to be completed by 01/07/2016

-Wound Management Skin Integrity and Pressure Area Care – to be completed by 01/07/2016

CNM/PIC will observe how all staff communicate with residents, where a staff member is not communicating in an acceptable manner, they will be spoken to and if deemed necessary will have a performance review – this will be on-going

We are also reviewing our Governance layout and what each positions roles and responsibilities will be. This will involve monthly governance meetings with a new set agenda that will include complaints and a status report on each open complaint. – to be completed by 31-08-2016

We are reintroducing weekly nurses meetings that will be run by the CNMs. Complaints will be a topic on the agenda so that the CNMs can gain feedback from other nurses regarding policies and procedures implemented due to complaint been made. It is an opportunity for the staff nurses and CNMs to discuss staff performance and staffing levels. - to be completed by 01-07-2016 and on-going

As we review our complaints policy we will be updating it to reflect the changes of the nursing system used, the change in Governance, new paperwork and who will be responsible for overseeing the complaint from start to finish. We will also update the complaint procedure that can be found in the main hallway of the nursing home. The complaint policy and notice will also identify who the person can speak with if they are not satisfied with the outcome of the complaint – to be completed by 31-07-2016

All complaints that have been closed will be reviewed and followed up a month afterwards. This will be done by speaking with the person who initially made the complaint and looking at the policies and procedures that were implemented – on-going

Proposed Timescale: 31/08/2016

Theme:

Safe care and support

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

All staff had not received training in the protection of vulnerable adults and detection and prevention of abuse.

7. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

All staff have now received training on the protection of vulnerable adults and detection and prevention of abuse

Where a staff member does not show up for training, we will continue our procedure of having them attend the next training scheduled. We will now speak with the staff member and place a note on their file if they do not turn up to trainings. This will be monitored.

When an employee commences employment we endeavour to allocate them to this training within their first couple of weeks.

On average elder abuse training is scheduled once a month

Proposed Timescale: Completed

Proposed Timescale: 17/06/2016

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:

The activities programme in place was not linked to residents' preferences or interests as these were not assessed or documented.

8. 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:

Many of our residents have been here many years and their past preferences are no longer relevant due to the current stage of their disease. However every effort is taken

to ensure each resident engages in some activity each day unless they have verbalised that they do not wish to engage

We view each resident's quality of life as being crucial to their overall care. Many of our residents with Dementia no longer have the ability to tell us what their preferences or interests are. However all residents are asked and encouraged to join in all activities, irrespective of their decision making abilities.

Our current activity programme was created by our OT who spent a lot of time with each resident finding out their preferences to different activities, their interests and finally assessing their abilities to take part in each of the preferred activities. Based on all this a programme was created.

We have employed a new member to the activity team. She has a Diploma in Dementia Care and previously gave training on Dementia. She has been working with the residents and getting to know them. The four-month plan is to reassess all the residents using the activity assessment and activity plan. The information gathered will help her to review the activity programme and make changes where necessary with the rest of the activity team.

We are also trying to organise different outings for the residents over the coming months, this involves a lot of planning, funding and interest from the residents themselves. We are looking to get the families more involved also.

As previously mentioned all residents are being assigned a key HCA. Each resident will be asked if there is something they would like to achieve. The key HCAs will be there to assist and encourage the resident to accomplish this goal.

Proposed Timescale: 30/11/2016

Theme:

Person-centred care and support

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

Residents were not fully supported to exercise their civil or political rights in relation to voting or choices in rising or returning to bed

9. Action Required:

Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

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

All residents are facilitated to exercise their civil and political rights – they will be brought to the voting centre on the day of election if they so wish by members of staff – this has been custom and practice for many years

We will look into organising a postal voting and setting up a polling station in the nursing home for residents.

For the next vote, we will ask all residents who have the capacity to vote if they wish to use their vote. We will document in the each residents care plan their wishes. Those who want to vote we will organise a staff member to bring the resident to the polling station, if a family member is unable to take them.

Residents are asked their wishes in relation to mealtimes, bedtimes and all other activities of daily living and their wishes are complied with, unless the action will have a negative impact on another resident. At times there are some restrictions for certain residents in relation to the length of time they are able to stay in an upright seated position and on medical direction they must return to bed after a number of hours, the time of day that the resident is not in bed is their choice where they have the ability to exercise this decision.

After tea time, some staff are allocated to assist residents to bed. These staff will ask residents to inform them know when they wish to go to bed. Some residents who do not have the mental capacity to tell the staff when they wish to go to bed are observed and when the staff observe the resident is beginning to fall asleep they will be assisted to bed. Again these residents will be asked even if they are unable to answer us. We do have some residents who again do not have the capacity to tell us when they wish to go to bed but because of their routine over the years and before the condition deteriorated; we assist them to bed at certain times. Again, the residents are asked even if they are unable to answer us. No resident is ever forced to do anything they do not wish to do

In the morning the night staff hand over to the day staff information such as residents who did not sleep well or who went to bed late. These residents will not be disturbed until later in the morning so they can get more sleep. In the case of residents who do not have the ability to tell us when they wish to get up, we speak with the families in order to get an idea of their habits when they lived at home. Also, as we get to know the residents, we are able to distinguish when a resident likes to get up based on their reactions and their willingness to assist in the morning. If a resident does not wish to wake up we simply leave them to sleep a little longer and return to them later in the morning. The HCAs pass on information like this to the nurses so care plans can be updated and information passed on to other HCAs.

A review of all care plans will ensure that each individual resident's wishes are documented – and also to ensure that if a resident wishes to change their normal routine for any reason that their wishes are followed.

Proposed Timescale: 15/07/2016

Theme:

Person-centred care and support

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

Access to community events was limited for residents.

10. Action Required:

Under Regulation 09(3)(c)(iv) you are required to: Ensure that each resident has access to voluntary groups, community resources and events.

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

During the summer months a number of activities will be organised for the residents on the seafront – these will include picnics, afternoon tea, a glass of beer in local beer garden etc. Also we hope to bring some residents to the mermaid theatre. This will be ongoing, different activities will be organised during the different seasons

Community resources are not always available to residents in nursing homes as these groups find that their resources are stretched to the limit with people still living in the community and will not accept residents from nursing homes

Residents themselves are left with minimal funds from their pensions once their Fair Deal contribution, prescription charges etc. are taken which rules out many activities – in the past we have fund-raised here in the home to bring resident's on outings and plan to do this again in the future.

Proposed Timescale: 31/12/2016

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

Evidence that a detailed investigation was conducted into all complaints made was not found. Reviews of satisfaction further to resolving the complaints were not always documented.

11. Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

All information is recorded in our nursing system software. Since the inspection we have upgraded our nursing system. The complaints section of this has become more detailed and there are more steps involved in the complaints process. This will guide the complaints procedure and make it more robust. We are now using this new system for any complaints received – COMPLETED

We are also reviewing our Governance layout and what each positions roles and responsibilities will be. This will involve monthly governance meetings with a new set agenda that will include complaints and a status report on each open complaint. – to

be completed by 31-08-2016

As we review our complaints policy we will be updating it to reflect the changes of the nursing system used, the change in Governance, new paperwork and who will be responsible for overseeing the complaint from start to finish. We will also update the complaint procedure that can be found in the main hallway of the nursing home. The complaint policy and notice will also identify who the person can speak with if they are not satisfied with the outcome of the complaint – to be completed by 31-07-2016

We will create a template letter that is sent to the person making the complaint to acknowledge we have received the complaint and what our initial steps will be. It also details an overview of what the procedure will be and at what stages we will be in contact. – COMPLETED

We will create a template form that will describe the methodology of how we intend to deal with the complaint. This will state how we intend to carry out the investigation, who will be involved in carrying out the investigation, who will be interviewed and by whom, if policies, assessment, care plans etc need to be consulted, if outside agencies need to be considered, what forms need to be completed and by whom, time frames will be set, and the person who is responsible for overseeing the whole complaint process. - COMPLETED

We will create a template interview form that is completed when interviewing people during an investigation. This details the complaint, the name of the person conducting the interview, the name of the interviewee, the questions asked and the responses and the signatures of those involved. – COMPLETED

We will create a template letter that we will give to the person who made the complaint which will detail the finding of the investigation and what the outcome is. It will also state what we intend to do following the investigation to ensure this will not happen again. It will also state who they wish to talk to, both internally and externally, if they are not satisfied with the outcome – COMPLETE

This letter will be given to the person who made the complaint during a meeting where we will discuss the content of the letter face to face. This meeting will be documented in the nursing system – on-going

Also documented in the nursing system will be the key findings of the investigation, the outcome, what improvements can be made having conducted the investigation and any other information that is deemed necessary.

All complaints that have been closed will be reviewed and followed up a month afterwards. This will be done by speaking with the person who initially made the complaint to see if they are still satisfied and by looking at the policies and procedures that were implemented – on-going

All forms that are completed will be scanned and saved on the network should we need to revisit any stage.

At the monthly Governance meetings the person with the responsibility for overseeing

these processes will give a status update on all open complaints and follow ups.

Proposed Timescale: 31/07/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Documents required under Schedule 2 of the Regulations were not held in the centre for all members of staff, including evidence of garda vetting, two written references or details of qualifications and experience.

Staff rotas did not include the full names of all staff or the names of all staff working in the centre. The rota did not include the hours being worked by all staff.

12. 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:

The Garda vetting unit are now accepting vetting forms, they have not accepted any since 31-03-2016. All new employees were asked to complete the forms and these are on file. Since the inspection, NHI have sent out new forms which have all been completed and returned to NHI for vetting. Since these forms have been sent in the Garda Vetting Unit has activated their online vetting system and all new employees will be vetted following these new procedures

2 references are sought for each employee before they commence employment. However, this always proves difficult, as it can take referees time to respond and return the forms due to their work and time constraints. It is the same when trying to complete over the phone references, many referees cannot provide the time when the call is made. Every effort is made to have 2 references pre employment. All emails and calls made are documented and where possible evidence is kept (delivery reports with emails). When a referee does not respond to the reference request, a reminder email is sent after 2-3 days. Going forward we will halt the start dates until references are received.

In relation to details of experience and qualifications, all staff have this on their file before they start employment as we require a CV before the interview stage.

Again at interview stage all candidates are required to bring ID and evidence of their qualification and trainings completed. In future if this is not adhered to, we will give them an opportunity to send us evidence of their qualification. If this does not happen we will remove them from the list of potential candidates

Proposed Timescale: 17/06/2016

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:

All aspects of the design and layout of the centre were not suitable for the purpose of achieving the aims and objectives set out in the statement of purpose as identified on previous inspections.

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:

Planning permission was applied for on the 13 May 2016 for the garden level phase of a projected development.

Development plans for the building compliance phase have been notified and at a meeting with HIQA on the 30 May 2016 these plans were discussed and issues regarding this were noted and will be added to the plans.

Proposed Timescale: 31/07/2017