

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Carechoice Montenotte
Centre ID:	OSV-0000253
Centre address:	Middle Glanmire Road, Montenotte, Cork.
Telephone number:	021 486 1777
Email address:	montenotte@carechoice.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Carechoice Montenotte Limited
Provider Nominee:	Paul Kingston
Lead inspector:	Caroline Connelly
Support inspector(s):	Maria Scally; Niall Whelton
Type of inspection	Announced
Number of residents on the date of inspection:	90
Number of vacancies on the date of inspection:	21

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 August 2016 08:50	10 August 2016 18:50
11 August 2016 08:40	11 August 2016 19:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This report sets out the findings of an announced registration renewal inspection which took place over two days. The provider applied to renew the registration of the centre which will expire on 16 January 2017. As part of the inspection Inspectors met with residents, relatives, the provider, the person in charge, the six Clinical Nurse Manager (CNM) one who deputises for the person in charge, the clinical director,

nurses and staff members. Inspectors observed practices and reviewed all governance, clinical and operational documentation to inform this registration renewal application.

The provider, person in charge, the clinical director and CNM displayed adequate knowledge of the regulatory requirements when interviewed during the inspection and they were found to be committed to providing person-centred, evidence-based care for the residents. Many of the actions required from previous inspections relating to the premises were not completely remedied, nonetheless, the inspector viewed numerous improvements throughout the centre which are ongoing and there was substantial renovation works taking place during the inspection.

A number of completed questionnaires from residents and relatives were received and the inspector spoke with residents during the inspection. The collective feedback from residents and relatives was mostly one of satisfaction with the service and care provided however staffing levels, and lack of access to safe outdoor space were identified as key concerns on a number of questionnaires and these will be addressed under the relevant outcomes in the report. Overall, inspectors found that there was evidence of good care practices in meeting the day-to-day needs of residents. Staff were kind and respectful to residents and demonstrated good knowledge of residents and intervention necessary for those with divergent needs.

Inspectors were satisfied that residents had access to the services of a general practitioner (GP) and other healthcare professionals on a regular basis. There was evidence of choice for residents in their day-to-day living with personal preferences accommodated as requested. A regular routine of daily supervised activities was in place and undertaken by a dedicated activity coordinator. Independence of residents was promoted and many were observed mobilising throughout the centre.

Inspectors found improvements in a number of key areas since the previous inspection, which had a demonstrable effect on improving residents' quality of life. These included the provision of very comfortable seating areas outside the front of the building, extensive firework had taken place to ensure the centre was fire compliant, new flooring was being put in place on the corridor areas throughout the centre, a full programme of redecoration was taking place and a number of small twin bedrooms had been converted to single rooms. Further attention was required in the provision of a secure outdoor space, further dining space and floor covering in a number of bedroom areas. This will be discussed further under outcome 12 premises. Inspectors also identified the need for improvement in complaint handling and the documentation and monitoring of allegations of abuse. Further improvement was also required in the notification of incidences to HIQA as required by legislation. These areas and other actions required are detailed in the body of the report, which should be read in conjunction with the action plan at the end of this report. The action plan at the end of the report identifies improvements necessary 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.

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: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose consisted of the aims, objectives and ethos of the designated centre and statement as to the facilities and services that were to be provided for residents. All items listed in Schedule 1 of the regulations were detailed in the statement of purpose. The inspector noted that the statement of purpose was made available for residents, visitors and staff to read. The statement of purpose had been reviewed in July 2016.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a clearly defined management structure. The person in charge was supported in her role by six Clinical Nurse Managers (CNM). The person in charge reported to a

clinical director who was also responsible for a number of other centres. The clinical director reported to the chief executive officer (CEO). Since the last inspection there had been a change to the directorship of the organisation and to the provider nominee and the statement of purpose was updated to reflect this change.

There were regular management meetings held in the centre that were attended by the person in charge, the CEO, the clinical director, chief financial officer, facilities manager and human resources manager. Minutes of these meetings were available for review and indicated that issues discussed included staffing levels, staff training and all managerial aspects of the running of the centre. The person in charge met formally with CNM's, and the CNM's met with nursing staff and care staff on a regular basis and informally on a daily basis.

The auditing programme was well established with key performance indicators (KPIs) reviewed monthly and weekly recording. There was a monthly programme of audits that included audits of falls, medication management, accidents/incidents, psychotropic medications, end of life, restraint and the environment. Although there was some evidence of action in response to issues identified this could be further developed. This was particularly relevant in the monitoring of medication errors there had been 28 medication errors since the start of the year which the staff had diligently reported. However, there was no trending of these errors to establish patterns, times of errors etc. There was no evidence of comprehensive actions plans put in place following these errors to prevent their reoccurrence, this is also discussed under outcome 9 Medication Management. There was also no system of spot checking or auditing of residents finances by the management team to ensure the system was sufficiently robust to protect residents and staff. The monitoring and oversight of complaints was found by inspectors to also require review to ensure there was a consistent approach throughout the centre as the CNMs generally recorded complaints. CNMs on different floors described different recording methods to the inspector this is discussed further under outcome 13 Complaints management. Overall inspectors concluded that further development of the audit and quality assurance system was required to ensure the quality and safety of care and the quality of life for residents was continually evaluated.

There was a relative satisfaction survey undertaken in 2016, 16 relatives completed the questionnaire the feedback was positive. Questionnaires completed by residents and relatives were also positive but did identified that at times they did not feel there was enough staff on duty and they would like to see more access for residents to the outdoors. This is discussed further under outcome 18 staffing and 12 premises..

There was an annual review of the quality and safety of care completed for 2015 which included the quality improvement plan for 2016. It addressed issues such as recent improvements to the premises, results of residents and relatives questionnaires and the residents' dining experience and was presented in a format that was accessible to both residents and relatives. Action plans were in place following questionnaires and quality initiatives were set and outlined for 2016.

There was an active residents committee and regular residents meetings took place and residents spoken to said their input into the daily running of the centre was encouraged. Residents stated they had influenced the activity programme and new activities had

been introduced this year as a result of their suggestions along with changes to the menu.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents

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

Theme:
Governance, Leadership and Management

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

Findings:
Random samples of resident contracts were reviewed. They were seen to set out the services to be provided and the fees to be charged including any additional fees. Those contracts viewed were dated and signed by the resident and/or their representative and met the legislative requirements.

A Residents' Guide was also available which included a summary of the services and facilities provided, terms and conditions relating to residence, procedure respecting complaints and the arrangements for visits. This guide was found to meet the requirements of legislation.

Judgment:
Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
The nominated person in charge holds a full-time post in the centre, she is a registered nurse, holds current registration with the nursing professional body and she has extensive managerial experience and has been in charge of the centre for nine years.

There were six clinical nurse managers (CNMs) in post to support the person in charge in her role and they are identified as key senior managers.

There was evidence that the person in charge has a commitment to her own continued professional development and had attended relevant education sessions and training updates. During this inspection she demonstrated to inspectors that she had the necessary clinical knowledge and she had an understanding of her responsibilities in regard to 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.

Residents, relatives and staff were able to identify her as the person in charge and she was engaged in the governance and the operational management and administration of the centre on a regular and consistent basis and this was confirmed by residents and staff.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

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

Findings:

Records were kept securely, were accessible and were kept for the required period of time. Residents' records were kept in a secure place. Inspectors found that the system in place for maintaining files and records was very well organised with clear processes in place.

The inspector reviewed a sample of staff files and found that they generally contained all of the information required under Schedule 2 of the Regulations except for two staff files which did not contain full employment histories together with a satisfactory history of any gaps in employment as required by legislation.

The Directory of Residents was reviewed by an inspector who found that it complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated

Centres for Older People) Regulations 2013. Residents' records as also required under Schedule 3 of the Regulations were maintained and inspectors found that the medical and nursing records were comprehensive. The care plans and the record of care provided to residents were accurately documented. The records listed in Schedule 4 to be kept in a designated centre were all maintained and made available to inspectors.

The designated centre had all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and these have review dates at intervals not exceeding three years as required by Regulation 4.

Judgment:
Compliant

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Governance, Leadership and Management

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

Findings:
There had been no instances since the last inspection whereby the person in charge was absent for 28 days or more and the person in charge was aware of the responsibility to notify HIQA of any absence or proposed absence and this had been notified in the past.

There were suitable arrangements in place should the person in charge be absent. There were six clinical nurse managers (CNMs) in place, one of the CNMs was supernumerary and generally was appointed to deputise for the person in charge in her absence. She was a nurse with relevant experience in nursing the older adult. She was engaged in the governance of the centre on a regular basis and demonstrated a commitment to her continuing professional development. CNMs and senior nurses were also part of the staff complement to support the person in charge and take charge of the centre in the absence of the management team at weekends and evenings.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment

is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There is a policy in place in the centre in relation to the prevention, detection and response to abuse which was reviewed on 28 September 2016. Inspectors found that there were measures in place to protect residents from suffering harm or abuse. Staff interviewed by inspectors demonstrated understanding of safeguarding and elder abuse prevention and were clear about their responsibility to report any concerns or incidents in relation to the protection of a resident. However inspectors found that there were incidents of peer on peer abuse and a number of incidents of allegations of abuse by staff that had been recorded as incidents and complaints and not as allegations of abuse as required by legislation and not notified to HIQA as also required by legislation. The lack of notifications is outlined under outcome 10 notifications. There was evidence that the allegations of abuse by staff had been recorded as complaints on the computerised system and investigated by the CNM and an action plan was put in place. However these should have been investigated and managed under the safeguarding policy as required by legislation. Overall the inspectors found that the systems in place to record and manage allegations of abuse required immediate review and this was discussed at the feedback meeting.

The inspector saw that safeguarding training was ongoing and training records confirmed that most staff had received this mandatory training. Two new staff members had yet to receive training in this area and two staff members were also overdue refresher training. However, this training was scheduled to take place on 23 August 2016.

There is a policy in place for residents' personal property, finances and possessions dated October 2013. The centre maintained day to day expenses for a number of residents and inspectors saw evidence that complete financial records were maintained. Inspectors reviewed the systems in place to safeguard residents' finances which included a review of a sample of records of monies handed in for safekeeping which were found to be in order. Inspectors noted that the cash book which recorded money handed in for safekeeping did not have two signatures from staff members and there was no evidence that the balances of these monies was audited on a regular basis to ensure the system was sufficiently robust to protect residents and staff.

There is a policy in place in the centre in relation to the management of responsive behaviour which was reviewed on 18 March 2016. Inspectors reviewed the policies which outlined guidance and directions to staff as to how they should respond and strategies for dealing with behaviours that challenged. The policy on restraint was based on the national policy and included clear directions on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used

for the shortest period possible. Staff continued to promote a reduction in the use of bedrails, there were 29 residents using bed rails at the time of inspection and the inspector saw that alternatives such as low low beds, crash mats and bed alarms were in use for some residents. Inspectors reviewed a sample of files of residents using bedrails and found that risk assessments detailing alternatives tried and considered as well as care plans guiding care were documented. Regular checks of all residents were being completed and documented.

Inspectors observed that residents generally appeared relaxed and content during the inspection. Inspectors reviewed a sample of files of residents presenting with responsive behaviours and noted that comprehensive care plans were in place to guide staff in addition to behavioural support plans. There was evidence that residents who presented with responsive behaviour were reviewed by their GP and referred to psychiatry of old age or other professionals for full review and follow up as required. Inspectors saw evidence of positive behavioural strategies and practices implemented to prevent responsive behaviours. The records of residents who presented with responsive behaviours were reviewed by the inspector who found that these were managed in a very dignified and person-centred way by the staff using effective de-escalation methods as outlined in residents' care plans.

Many staff spoken with and training records reviewed indicated that staff had attended training on dementia care and in dealing with responsive behaviours. However, training records showed that there were a number of staff that had not received up to date training in responsive behaviours as is required by legislation. Eighteen staff members had yet to attend dementia training which incorporated dealing with responsive behaviours.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that the centre had the necessary plans and policies in place in relation to risk management and health and safety. There was also a risk register which demonstrated good risk management practice. Risks were assessed and control measures were implemented in the centre. However, not all risks were found to be identified. For example, there was a trip hazard near the main entrance to the building where the top of the sloped area met the level paving. There was a hot water dispenser at the sink which dispensed water at near boiling point, which was available for staff, visitors and residents to use. The base of the timber ramps to the timber decking was

damaged resulting in sharp timber edges and a significant trip hazard.

The environment was observed to be clean and personal protective equipment, such as gloves, aprons and hand sanitizers were located throughout the premises. All hand-washing facilities had liquid soap and paper towels available. There were policies in place on infection prevention and control and staff that were interviewed demonstrated knowledge of the correct procedures to be followed. Hand hygiene training was ongoing and staff demonstrated good hand hygiene practice as observed by inspectors.

However, inspectors observed some items of torn furniture that required repair or replacement. In addition, inspectors found there to be inadequate provision of staff changing facilities, which did not meet the requirements of infection prevention and control. There was no bedpan washers available in the centre, the person in charge said they are to be purchased in the near future.

From a fire safety point of view, the inspector reviewed the fire safety management practices in place, including the physical fire safety features of each building. The inspector also examined records for maintenance, fire safety training of staff, evacuation procedures and programme of drills.

The inspector found that the centre was provided with robust fire safety management policies and procedures. The inspector spoke to a number of staff who were found to have consistent responses and very knowledgeable with regard to the procedure to be followed in the event of a fire.

The inspector noted that the centre was provided with emergency lighting, fire fighting equipment and a fire detection and alarm system throughout.

The fire detection and alarm system was provided with a main panel adjacent to the reception and additional repeater panels located centrally on each upper floor adjacent to the nurse station. The system was capable of identifying the location of an activated device. The system did not have the coverage in line with an L1 type fire detection and alarm system, which would be required in a building of this type. There were a number of store rooms, sluice rooms and so on, where the fire detection and alarm system coverage was not extended. The inspector was informed that the work being carried out in the centre would include the extension of the fire detection and alarm system into these areas.

Records showed that the emergency lighting, fire fighting equipment and a fire detection and alarm system were being serviced and were up to date. However, the emergency lighting system was not being serviced on a quarterly basis as would be required in the appropriate technical standard.

The necessary routine fire safety checks in relation to exits, escape routes and fire safety systems were all being carried out and were found to be of adequate extent, frequency and detail.

The provider had made arrangements for appropriate fire safety training to be provided to staff and associated records kept. However, documentation available to inspectors indicated that some staff had not received refresher training within the previous 12 months. The inspector was informed that the necessary arrangements had been made

for these staff to receive the necessary training in September 2016.

The inspector found records which indicated that regular fire drills were taking place. However, records indicated that the fire drills appeared to simulate staff response to the alarm being raised only and did not follow through to replicate a real fire scenario in terms of realistic staffing availability, particularly in terms of night time staffing. As no evacuation was simulated, it was not clear if the staffing, equipment and training requirements were adequate at all times within the centre. There was no evidence that any worst case scenario, such as the evacuation of the largest bedroom fire compartment with night time staffing levels, had been simulated as part of the fire drill program.

The inspector found that there was a fire procedure in place and was appropriately displayed throughout the centre in both written and drawing format. The extent of the fire compartments, in terms of progressive horizontal evacuation, was clearly portrayed and legible.

The inspector found that the needs of residents in the event of a fire were assessed by way of Personal Emergency Evacuation Plans (PEEPs), which formed part of each resident's care plan. There was also a summary sheet which contained the name of each resident and their level of mobility in code form available at each nurse station and at reception. Although the PEEPs were comprehensive in their content, they would benefit from additional info to differentiate between the method of transfer to an evacuation aid for both daytime and night time scenarios. In addition, of the samples seen by the inspector, the section detailing what a staff member assisting the residents needs to do, was left blank.

The inspector found the centre to be of a layout which provided residents, staff and other occupants with an adequate number of escape routes and fire exits. Escape routes were kept clear, and access to escape routes was readily available upon activation of the fire detection and alarm system.

The building was subdivided with construction which was capable of restricting the passage of fire and smoke in most cases. Recent work to the building included the further sub-division of fire compartments for the purpose of progressive horizontal evacuation, thereby greatly reducing the risk to residents and assisting evacuation. Fire doors in general were furnished with the appropriate features comprising a fire rated door set. However, there were a number of instances where self closing devices were not provided, portions of intumescent strips and cold smoke seals missing and a small number of doors catching on the floor covering. It is acknowledged that the building was undergoing some material alterations and renovations which contributed to the deficiencies noted to the fire doors. It is noted, that overall, the provision and condition of the fire doors throughout the centre were of a good standard and being maintained appropriately.

The inspector looked at the kitchen and laundry rooms and found them to be well laid out and provided with appropriate fire precautions in terms of staff knowledge and systems in place. However, it was found that the lint from the dryers in the laundry rooms was being removed once per day. A risk assessment was available which

indicated that the lint should be removed in line with the manufacturer's instructions, however, inspectors were informed that the removal of lint would take place after each machine cycle.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

There was a centre-specific, up-to-date medication management policy detailing procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. Nursing staff with whom the inspector spoke demonstrated good practice regarding administration of medicines. Photographic identification was in place for all residents as part of their prescription/drug administration record chart. Controlled drugs were maintained in line with best practice professional guidelines and they were checked and counted at the beginning of each shift. The inspector saw evidence of this checking process and the count undertaken by the inspector was found to tally with records in the centre. The medication trolleys were securely maintained and a nurses' signature sheet was in place as described in professional guidelines.

The inspector found that in the sample of drug charts reviewed that all as required medications had the maximum dose recorded on the prescription chart and residents who required their medications to be crushed were prescribed as so by their general practitioner (GP).

Medications were delivered in monitored dosage units and these were checked by nursing staff to verify that what was delivered corresponded with prescription records. Inspectors reviewed prescription and administration records. The person in charge and staff reported to the inspector that the pharmacist is easily accessible regarding advice relating to drug interactions, dosages, crushing of medicines and possible alternatives in prescriptions and regularly liaised with the relevant GPs regarding prescriptions. Medication management audits were completed on a regular basis by the pharmacist and these were evidenced during inspection. Medication errors were recorded and the inspectors viewed records of same. There had been 28 medication errors recorded since the start of 2016 and the inspectors found staff were vigilant in their reporting and recording of medication errors. However, there were no comprehensive action plans put in place by the centre following the medication errors, there was no evidence of review

of the system, review of staffing levels or extra training and support put in place for staff to mitigate the risk of reoccurrences. This was actioned under outcome 2 Governance and Management.

There were appropriate procedures for the handling and disposal of unused and out of date medications. There were medication fridges in the centre which were kept in a locked room and daily temperatures were recorded.

There was evidence that residents' medicine prescriptions were reviewed at least every three months by a medical practitioner.

Nursing staff transcribed the medication prescriptions onto the centres medication chart which was then signed by the GP prior to any administration from that chart. The centres policy stated that a second nurse must check and sign the transcribed prescription however the inspector saw on one unit that on many resident's medication chart there was only one nurses signature which is in convention of the centre's policy and best practice guidelines. The action for this is recorded under outcome 5 documentation.

Judgment:
Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

No actions were required from the previous inspection.

Findings:

It is a requirement of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 that all serious adverse incidents are reported to HIQA. Notifications received by HIQA were reviewed upon submission and prior to the inspection. Notifiable incidents and quarterly returns submitted to HIQA were generally timely and comprehensive. Inspectors saw that a record was maintained of incidents occurring in the centre and these generally correlated with residents' care plans. Appropriate interventions were documented and evidenced, to support the notifications. However although a record of all incidents occurring had been maintained, there were a number of incidences reviewed on inspection that had not been notified to HIQA as required by the regulations. These included a number of allegations of abuse of a resident, allegations of staff misconduct and a notification of a serious injury to a resident had not been sent to HIQA.

This was discussed with the provider and person in charge that even if an allegation of abuse or misconduct is investigated and found not to have occurred, it is still a

requirement that any allegation of abuse or misconduct by staff is notified to HIQA within three days of the event occurring.

Judgment:

Non Compliant - Major

Outcome 11: Health and Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors saw that residents' healthcare needs were met through timely access to the centre's general practitioner (GP) service and an out of hours service was also available. There was evidence of monthly weight checks and more frequently if the residents' healthcare needs required it. Regular blood pressure and blood glucose monitoring was also undertaken and records confirmed this. There were processes in place to ensure the safe admission, transfer and discharge of residents to and from the centre. There was evidence that staff provided care in accordance with any specific recommendations made by medical and allied health professionals

There was evidence of regular nursing assessments using validated tools for issues such as falls risk assessment, dependency level, moving and handling, nutritional assessment and risk of pressure ulcer formation. Other assessments such as pain assessments oral cavity assessments dementia or depression screening are undertaken as required. These assessments were generally repeated on a three-monthly basis or sooner if the residents' condition had required it. Care plans were developed based on the assessments. The CNM and staff on the units demonstrated an in-depth knowledge of the residents and their physical, social and psychological needs and this was reflected in the comprehensive person-centred care plans available for each resident. Nursing notes were completed on a daily basis and there was evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated and care meetings took place.

Residents' additional healthcare needs were met. A chiropody service is provided to the residents on a regular basis in the centre. Dietician and speech and language services were accessed via a nutritional company. Physiotherapy services were provided in-house weekly through group exercises and one to one reviews and treatments. The inspector

saw evidence of referrals and reviews in residents' notes. Inspectors also observed that residents had easy access to other community care based services such as dentists and opticians.

There were very good links with psychiatric services and community services for residents who required these services and assessments and treatment reviews were seen in residents notes.

Inspector were satisfied that facilities were in place so that each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care and appropriate medical and allied healthcare. Residents, where possible, were encouraged to keep as independent as possible and inspectors observed residents moving freely around the corridors. Residents and relatives said they were satisfied with the healthcare services provided.

Judgment:
Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:
Effective care and support

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

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

Findings:

Care choice Montenotte has been in operation as a designated centre since 2003 and has capacity to accommodate 111 residents. There are four floors each of which is a self contained unit provided with day rooms, kitchenette, dining room, staff areas, sluice rooms, assisted bathrooms and storage rooms, a treatment room and a nurse's office. The centre is serviced by a fully functioning lift between all floors. The centre has a lower ground floor for laundry areas; the ground floor has staff areas, and areas for catering and waste, visitor's canteen, reception and administrative offices as well as bedrooms on dedicated corridors. . All floors can be accessed by stairs or a lift and records showed the lift was serviced on a regular basis.

There were substantial building and renovation works ongoing since the last inspection including extensive fire works which included the further sub-division of fire compartments for the purpose of progressive horizontal evacuation, thereby greatly

reducing the risk to residents and assisting evacuation. New flooring was being put in place on all corridor areas. Smaller twin rooms were reconverted to single rooms and some office space were converted to bedrooms therefore maintaining the number of beds. The entrance to the dining room on one floor had been changed to facilitate easier access, there had been a comprehensive programme of painting and redecoration throughout. A new outdoor seating area had been developed at the entrance to the building which was seen to be enjoyed by residents and relatives alike. This programme of works was due to be completed in a number of months. The additional facility on the ground floor of the canteen and day room for residents to meet their visitors was seen to be finished and decorated to a high standard.

The necessary assistive equipment was available such as commodes, hoists, wheelchairs and specialised seating and records indicated that equipment was well maintained and serviced frequently. There were appropriate beds and mattresses to meet residents' needs and in shared bedrooms there was adequate screening curtaining. Some of the residents had personalised their bedrooms with family photographs, pot plants and favourite ornaments.

A high level of cleanliness and hygiene was maintained in the centre. Cleaning staff were working in an unobtrusive manner which did not disturb residents. Calls bells were provided in all bedrooms and communal areas. Inspectors viewed the servicing and maintenance records for the equipment and found they were up to date.

Inspectors identified a number of areas with the premises that continued to require improvement that had not been included in this phase of the renovation programme. Floor covering in a number of bedroom required replacing as it was damaged. Storage for equipment was limited and wheelchairs and specialist chairs were stored in day rooms taking from the homely feel of the centre.

The positioning of televisions in some twin bedrooms required review to ensure both residents had comfortable access.

There was no secure outdoor space where residents could access, as the external grounds were not suitable and safe for use by all residents as access to the walkway and garden area was through the car park.

Dining rooms were small and some were not easily accessed by the residents. Access in some units was through a kitchenette where serving trolleys and other kitchen equipment were stored.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The inspector reviewed the policy for responding to complaints which had last been reviewed on 24 September 2015 and found that it met regulatory requirements. Inspectors spoke with residents who stated they would be confident that if they made a complaint it would be dealt with appropriately. The person in charge is the person nominated to deal with complaints. The company directors were nominated to ensure that all complaints were responded to.

Inspectors reviewed the complaints log which contained information regarding investigations, responses and outcome of complaints made. On review of the log, it was found allegations of abuse had been logged in the complaints log and investigated under the complaints process. The providers and person in charge were informed by inspectors that allegations of abuse should be investigated under the safeguarding process. This was addressed further and actioned under Outcome 7. Inspectors also identified inconsistencies in the way that complaints were handled throughout the centre. The CNM responsible for each floor generally logged a complaint and took responsibility for its investigation and actions taken. An inspector spoke to all CNMs in relation to complaints management and different CNMs described different systems of managing complaints on their floors, some were not recording informal complaints on the official complaints log some were only recording them in the residents records. These practices are contrary to the requirements of legislation which requires that all complaints are properly recorded and that such records shall be in addition to and distinct from a residents care plan.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Care practices and facilities in the centre were designed to ensure that residents received end-of-life care in a way that met their individual needs and respected their dignity and preferences. There were written operational policies and protocols in place and staff with whom the inspector spoke were familiar with these. These policies were the subject of ongoing review and had been updated as required on the previous inspection.

Staff had initiated discussions with residents and relatives to ensure that their wishes were documented and end-of-life care plans were seen by the inspector in the files of residents. Residents had signed their care plans where this was possible and relatives were consulted to ascertain the wishes of residents who were cognitively impaired. The general practitioner (GP) was involved in advising and supporting residents and relatives if required. The person in charge said that the GP was very knowledgeable in palliative care and in symptom control for residents who required this.

Religious and cultural practices were respected and services were held in the centre weekly. Family and friends were facilitated to be with the resident when they were at the end of life stage. Residents of all religious denominations were visited by their Ministers as required. The 'HSE Guidelines on Multicultural Care' at the end of life, was available for staff reference. Residents, with whom the inspector spoke, told the inspector that the rosary was said daily for those who wished to participate. These practices were seen to be operational in the centre during the inspection. The CNM informed the inspector that residents had a choice as to their preferred place of death and this could include dying at home if the appropriate care was available.

Links were maintained with the community palliative care would see residents on referral from the GP if required. The centre had a syringe driver which could be used to administer symptom relieving medication at the end of life. Staff had received training in its use from staff in Marymount. The palliative care specialists visited the centre if required and would set up the syringe driver in consultation with the GP. Three of the clinical nurse managers (CNM) and the person in charge had undertaken a palliative care course. They had provided training for staff.

Staff with whom the inspector spoke said that the care at the end of life was person-centred and inclusive of the relatives. Other residents would pay their respects and the deceased person's room was left undisturbed for at least two days afterwards. The inspector observed that there was a genuine respect for the resident and family at the end of life stage and the staff said that they were given support also, at this time. Belongings and possessions were respectfully packed in special bags and the inspector noted that there were updated inventories of the residents' possessions in the care plans. Family were provided with leaflets and information about what to do following a death of a resident in the centre.

Single rooms were available for residents at the end of life and there was accommodation provided if the family wished to stay overnight. Staff informed the inspector that the families or friends would be given their meals and allowed to visit whenever they wished.

Judgment:
Compliant

Outcome 15: Food and Nutrition

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

discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy in place on monitoring and documenting residents' nutritional status. Inspectors observed that food and hydration needs were assessed on admission using the malnutrition universal screening tool (MUST) and on a regular basis following same. Inspectors observed mealtimes including breakfast, mid-morning refreshments, afternoon refreshments, lunch and teatime. There was a dining room on each floor however as discussed under outcome 12 premises some of the dining rooms were small in size and did not facilitate all residents to dine in the dining room. A number of residents dined at small tables in the sitting room where they sat for most of the day. The person in charge told the inspector that residents liked to dine in the day room but it was unclear whether daily dining choices were flexible as if they all choose to eat in the dining room there would not be space. The dining experience for residents required a review.

Referrals were made to dietician services for nutritional review and advice, and speech and language therapy if a resident had swallowing difficulties (dysphagia). There was evidence available in residents' records that allied healthcare recommendations were implemented by staff, such as the provision of appropriate diets and this was observed by inspectors. There was a system in place for communicating modified or special diets to catering staff and staff members spoken with were knowledgeable of residents' nutritional needs and requirements. Residents were weighed monthly and weekly if there were changes to their weight. There was evident that the documentation of a weight loss/gain prompted an intervention once a concern was identified including the commencement of food and fluid charts. Dietary assessments and nutritional care plans were seen in resident's notes.

The menus were varied, food appeared to be nutritious and residents were offered a choice at mealtimes. Residents requiring assistance were assisted in a dignified and respectful manner by staff. Residents had access to fresh drinking water and snacks were offered between meals and in the evening.

Inspectors viewed training records which indicated that staff had attended nutritional training. The inspector reviewed records of residents' meetings. It was evident that suggestions as regards to food choice were addressed and the chef attended residents meetings as required.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents and their relatives were provided with opportunities to provide feedback via satisfaction questionnaires and advocacy services were available for residents.

Inspectors noted that a survey had been completed at the end of January 2016 by 16 relatives and residents in relation to residents' satisfaction with services and the dining experience provided in the centre. Inspectors noted that the respondents to this survey generally reported high levels of satisfaction with the services provided.

Staff were observed treating residents and speaking about residents in a courteous and respectful manner. Inspectors observed residents' privacy and dignity being respected by staff as well as staff promoting residents' independence. Inspectors noted that a number of single bedrooms had a shared en-suite that opened into each bedroom. There was no signage on the door advising that the bathroom could be accessed from either room and to ensure the door was locked to prevent the resident in the next room entering the bathroom when in use. The person in charge said they would put signage up immediately.

The centre was suitably resourced with adequate daily entertainment and leisure facilities such as TV, radio and newspapers. Activities were available in the centre such as bingo, sensory sessions, physical activities sessions, pub afternoons, spa sessions and arts and crafts. Inspectors saw residents participating in and enjoying the various activities and residents told the inspectors how much they enjoyed them.

There was evidence available that indicated residents were consulted with and participated in the organisation of the centre as residents had been provided with opportunities to join the residents' committee meetings. A residents' meeting takes place in the centre approximately on a quarterly basis. This is chaired by one of the activities coordinators. Items discussed included laundry, housekeeping, meals, activities, staff, recent events that took place and issues that have arisen for residents. Following the meeting, a table is completed with the issues that the residents raised, who will address the issue and the response to the issue including how it will be addressed. This would be completed then for the next meeting. On average, between 18 and 24 residents would attend the meetings. Staff informed inspectors that for the other residents, the activities coordinators would visit the residents in their bedrooms and these residents would be able to raise any issues with the activities coordinators who would then look to

resolve the issue. However, although the issues raised by individual residents were documented, there was no documentary evidence available that these were followed up and resolved.

There was a good level of visitor activity throughout the days of inspection with visitors saying they felt welcome to visit. The inspectors met and spoke with a number of visitors who indicated that they had open access to visit their relatives. There were a number of areas throughout the centre where residents could receive visitors in private.

Residents were facilitated to exercise their civil, political and religious rights. Staff confirmed that residents can vote in the centre if they wish while some residents prefer to go to their own constituency to vote. Residents' religious preferences were ascertained and facilitated.

Judgment:
Compliant

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

Theme:
Person-centred care and support

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

Findings:
Inspectors found that there was a policy in place for residents' personal property and possessions, which included arrangements for the secure storage of residents' personal belongings. However, inspectors found that not all rooms were provided with a lockable storage space for resident's belongings.

The inspectors found that there were adequate laundry facilities in the building. There were appropriate systems in place in relation to infection and control. The laundry was adequately separated and there was a colour coded system to ensure that laundry was returned to the appropriate floor. Each resident had an allocated shelf for their clothing, and this together with the labelling of each item of clothing, ensured that clothing was successfully returned to the resident.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have

up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:

Residents and relatives spoke positively about staff and indicated that staff were caring, responsive to their needs, and treated them with respect and dignity. Staff demonstrated an understanding of their role and responsibilities to ensure appropriate delegation, competence and supervision in the delivery of person-centred care to the residents. Each unit had a CNM in charge supported either by a senior nurse or second CNM. There was evidence of good communication amongst staff with staff attending handover meetings. The inspector viewed minutes of regular staff meetings and noted that relevant issues were discussed.

Inspectors reviewed a sample of staff rosters, observed practices and conducted interviews with a number of staff. There was a nurse on duty at all times. Staff were generally supervised appropriate to their role. There had been a high turnover of nursing staff and if a unit could not get a second nursing staff they were replaced two care staff for the morning and one in the afternoon to ensure the nurse was able to undertake their nursing duties. The staffing levels at night reduced to three staff on two floors and only two staff on the ground and top floor from 20.00hrs. The inspectors found that these staffing levels were insufficient to ensure safe care to residents and ensure individualised practices in relation to choice of bedtimes and care practices were facilitated. From approximately 20.00hrs to 22.00hrs the nurse on duty would be administering the night time medications and should not be disturbed. This only left one member of staff on both the top and bottom floors to assist residents to bed, give out evening drinks, assist residents to the bathroom, answer the phone and the staff member on the ground floor may also have to answer the front door and direct visitors. Staff informed the inspectors, that a number of residents who required the assistance of two staff usually went to bed before the day staff went off duty. Inspectors held the view that the lack of staffing levels was dictating routine rather than residents individual choice. The staffing levels on the top floor also required review as the number of residents who will be residing on that floor once all the renovation work is completed will increase and staff levels will need to increase in line to ensure all the needs of residents can be met. A number of resident and relative questionnaires identified concern about staffing levels and call bells not being answered on time.

Records indicated that education and training was available to staff to support them in the provision of evidence-based care. Records indicated that three staff members were

overdue to attend refresher training in manual handling however this was being addressed on the first day of inspection as training was being provided. Some new staff had also yet to attend training in fire safety, dealing with responsive behaviours and protection of vulnerable adults, this is addressed under the relevant Outcomes. Staff spoken with were aware of the policies and procedures about the general welfare and protection of residents. Staff were also aware of the Health Act 2007, regulations and standards and could access these if required.

An up-to-date and centre-specific recruitment policy and procedures was in place and there was evidence that it was adhered to. An inspector reviewed a sample of the records that are to be maintained for staff, as per Schedule 2 of the Regulations, and there was evidence of substantial compliance as no documents were outstanding but there were gaps in CVs which is actioned under records in outcome 5. There was a human resources manager employed as part of the overall Carechoice management team who oversaw all aspects of recruitment and human resources.

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:

Caroline Connelly
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:	Carechoice Montenotte
Centre ID:	OSV-0000253
Date of inspection:	10/08/2016
Date of response:	26/09/2016

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 02: Governance and Management

Theme:
Governance, Leadership and Management

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

The system in place to manage medication errors was not sufficiently robust, there was no evidence of review of the system, review of staffing levels or extra training and support put in place for staff to mitigate the risk of reoccurrences.

The system for the oversight of complaints required review to ensure there was a more consistent approach.

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 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Medication errors: Medication errors (dispensing, ordering, documentation, administration) were documented diligently and reviewed individually, non-compliances were actioned and training provided.

A monthly audit of errors and trends will be conducted by the PIC and any non compliances / trends actioned immediately. These audits shall also be reviewed at the Clinical Governance meeting.

The Complaints Policy has been reviewed to ensure a more consistent approach and all complaints/concerns and comments shall be documented into the complaints book. Staff shall be informed with regard to the reviewed Policy.

Proposed Timescale: 30/09/2016

Outcome 05: Documentation to be kept at a designated centre**Theme:**

Governance, Leadership and Management

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

Inspectors found that the medication policy on transcribing medication prescriptions had not been fully adopted by staff in that the centres policy stated that a second nurse must check and sign the transcribed prescription however the inspector saw on one unit that on a number of resident's medication charts there was only one nurses signature which is in convention of the centres policy and best practice guidelines.

2. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

Nurses on the floor in question have been updated on the necessity of adhering to the Medication Policy, all Drug Kardex have been reviewed and now hold 2 nurses signatures.

All 4 floors are aware of this practice and the PIC shall monitor compliance.

Proposed Timescale: 23/09/2016

Theme:

Governance, Leadership and Management

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

Of the sample viewed, two staff files did not contain full employment histories together with a satisfactory history of any gaps in employment as required.

3. 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 staff files in question were those that pertained to staff members that had been in employment by the Nursing Home for a number of years. The files in question have since been completed i.e. the gaps in the CV.

All other files are undergoing a review to ensure that there are no further gaps to be found.

The HR Manager shall monitor ongoing compliance.

Proposed Timescale: 30/11/2016

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Training records showed that there were 18 staff that had not received up to date training in responsive behaviours as is required by legislation

4. Action Required:

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

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

Training has now been completed for all staff.

Induction and refresher training shall continue monthly.

Proposed Timescale: 30/08/2016

Theme:

Safe care and support

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

There was evidence that a number of allegations of abuse had been recorded as complaints and or incidents and were not investigated and managed under the centres safeguarding policy as required by legislation.

5. 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:

Following a review of the incident reports, careplans, ABC charts and responsive behaviour charts, which we use to guide the care of our residents' it has confirmed that there is a comprehensive practice of protection in place to protect our residents.

The PIC and CNM have attended further training on Safeguarding on the 21st September, where the HSE launched the new training programme, once completed, the current in-house programme shall be reviewed and updated. Applications to attend further training as Facilitators completed.

PIC undertakes to notify HIQA of any suspected/allegation of abuse.

Proposed Timescale: 23/09/2016 and on completion of training by NCPOP

Proposed Timescale: 23/09/2016

Theme:

Safe care and support

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

Inspectors noted there was no evidence that the balances of the monies handed in for safekeeping were audited on a regular basis to ensure the system was sufficiently robust to protect residents and staff.

6. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

Residents finances held onsite were signed for by the resident/NOK (if resident unable to do so) and a member of staff. All monies were correct at the time of the Inspection. Following a review of our procedure, a second member of staff shall witness and sign at each entry. An audit has been completed by our Financial Controller, and this shall be repeated on a monthly basis.

Proposed Timescale: 13/09/2016

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Improvements were required in relation to risk management as not all risks had been identified.

7. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

Risks have been identified (Trip hazard at the front of the building & Hot water dispenser) and entered into the Risk Register.

Ramps to timber decking to be replaced.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

There were some items of torn furniture that required repair or replacement.

There was inadequate provision of staff changing facilities

There were no bedpan washers

8. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Furniture shall be reviewed and where required repaired/replaced.

Staff changing facilities are to be provided under the current upgrade works.

Bedpan washers are on order.

Proposed Timescale: 31/12/2016
<p>Theme: Safe care and support</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect: The emergency lighting was not inspected on a quarterly basis in a manner prescribed in the relevant technical standard.</p> <p>9. Action Required: Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.</p> <p>Please state the actions you have taken or are planning to take: Testing of the Emergency lighting system shall be under taken on a quarterly basis in accordance with IS 3217. A service level agreement is in place with an Electrical Contractor to ensure this.</p>
Proposed Timescale: 30/09/2016
<p>Theme: Safe care and support</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect: Some staff had not received appropriate refresher training within the previous 12 months</p> <p>10. Action Required: Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.</p> <p>Please state the actions you have taken or are planning to take: Staff refresher training to be completed.</p>
Proposed Timescale: 30/11/2016
<p>Theme: Safe care and support</p> <p>The Registered Provider is failing to comply with a regulatory requirement in the following respect: The fire drill regime requires review to ensure that a realistic fire evacuation scenario is simulated.</p>

11. 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:

Fire evacuation drills to be completed on a quarterly basis, commencing 14th September 2016.

The drills carried out, shall be on a worst case scenario, with each drill being undertaken in different compartments over the year.

Learning from each of the evacuations shall be reviewed and actioned.

Proposed Timescale: 31/12/2016

Theme:

Safe care and support

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

The fire detection and alarm system was not extended to all areas consistent with a Type L1 system.

A number of fire doors required maintenance to ensure they would perform as required in the event of a fire.

12. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

The Fire detection and alarm system is currently being upgraded as part of the ongoing works within the building, to provide an L1 system in accordance with IS 3218.

All Fire doors have been reviewed and are now compliant.

Proposed Timescale: 31/10/2016

Outcome 10: Notification of Incidents**Theme:**

Safe care and support

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

A number of allegations of abuse of a resident, a notification of staff misconduct and a

notification of a serious injury to a resident had not been sent to HIQA.

13. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

The PIC undertakes to complete all notifications within 3 working days of an incident's occurrence.

Proposed Timescale: 23/09/2016

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Inspectors identified a number of areas with the premises that continued to require improvement that had not been included in this phase of the renovation programme.

Floor covering in a number of bedroom required replacing as it was damaged.

Storage for equipment was limited and wheelchairs and specialist chairs were stored in day rooms taking from the homely feel of the centre.

The positioning of televisions in some twin bedrooms required review to ensure both residents had comfortable access

There was no secure outdoor space where residents could access, as the external grounds were not suitable and safe for use by all residents as access to the walkway and garden area was through the car park.

Dining rooms were small and some were not easily accessed by the residents. Access in some units was through a kitchenette where serving trolleys and other kitchen equipment were stored.

14. 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:

Flooring to bedrooms shall be reviewed and all necessary flooring will be replaced by 31st December 2016.

The use of storage areas within the centre shall be reviewed to allow for storage of equipment in areas other than the day rooms.

The positioning of televisions within twin bedrooms shall be reviewed and adjusted to suit the needs of the residents within the rooms.

Secure outdoor space shall be provided for residents by 31st March 2017.

Dining rooms – 2 additional rooms identified as dining areas, should Residents choose to use the dining rooms-completed.

Access to dining rooms is now clearly available from the dayroom-completed

Proposed Timescale: 31/03/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

Inspectors identified inconsistencies in the way that complaints were handled throughout the centre. Some staff were not recording informal complaints on the official complaints log some were only recording them in the residents records. These practices are contrary to the requirements of legislation which requires that all complaints are properly recorded and that such records shall be in addition to and distinct from a residents care plan.

15. 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:

To ensure a more consistent approach the Complaints Policy has been reviewed and all complaints/concerns and comments of dissatisfaction shall be documented into the complaints book.

Staff shall be informed with regard to the reviewed Policy.

Proposed Timescale: 30/09/2016

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

There was not evidence that residents had choice as to where they had their meals as there was limited space in the dining room to facilitate all residents. The dining experience for residents required a review.

16. 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:

2 additional rooms have now been identified as dining areas

Areas in the Dayroom identified as dining areas are separate from seating areas-should residents choose to eat there.

Proposed Timescale: 23/09/2016

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

The inspectors were not satisfied that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

17. Action Required:

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

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

On the day of Inspection there were 90 Residents as a result of the significant refurbishment works ongoing in the Home. A decision was taken not to reduce staffing levels while this work is underway. A review of Staffing levels from 8pm to 10pm has been undertaken and an extra Staff member will be provided during this time.

Proposed Timescale: 31/10/2016