Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	St Colmcille's Nursing Home
Centre ID:	OSV-0005531
Centre address:	Oldcastle Road, Kells, Meath.
Telephone number:	046 924 9733
Email address:	stcolmcillesnh@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Fáinleog Teoranta
Lead inspector:	Leanne Crowe
Support inspector(s):	Una Fitzgerald
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	9

About Dementia Care Thematic Inspections

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
10 May 2018 09:00	10 May 2018 18:00
11 May 2018 07:00	11 May 2018 15:30

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	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Major
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Major
Outcome 08: Governance and Management		Non Compliant - Moderate
Outcome 10: Suitable Person in Charge		Compliant

Summary of findings from this inspection

This inspection was the third inspection since the registration of the designated centre in June 2017 with the Health Information and Quality Authority (HIQA) under the new provider entity. A new person in charge and clinical nurse manager (CNM) had been appointed since the previous inspection in December 2017. All three inspections to date have occurred as a result of receiving unsolicited information, on each occasion evidence has been identified that partially substantiated these concerns. At this inspection, the concern received related to pressure area care and

management of wounds. Inspectors found that the new person in charge had identified wound care as an area for improvement. It was clear that from the documentation reviewed that pressure sore monitoring, skin integrity management and wound management had been reviewed in recent months and improvements in practice had resulted in more positive outcomes for residents.

This report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. The journey of a number of residents with dementia within the service was tracked. Inspectors reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies including those submitted prior to inspection. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool. Prior to the inspection, the provider completed the self-assessment questionnaire in relation to six outcomes. The self-assessment and inspection judgements are set out on the table above.

Inspectors also followed up on the action plan from the previous inspection in December 2017, and findings indicated that four of the fourteen actions from that inspection had not been adequately progressed. While inspectors acknowledge that progress has been made in meeting some of the regulations, the findings of this inspection and previous inspections demonstrate that further improvements are required to bring the centre into full compliance with the regulations.

During this inspection, of the nine outcomes assessed, two major non-compliances and three moderate non-compliances were identified. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The centre has implemented an electronic care planning system.

Inspectors focused on the experience of residents with dementia and tracked the journey of a number of residents prior to and from admission into the centre. In addition files were reviewed on specific aspects of care such as wound care, nutrition, mobility, access to health care and supports, medication management and end of life care.

Arrangements were in place to support communications between the residents and their families, the acute hospital and the centre. The person in charge or deputy ensured that prospective residents' needs were assessed prior to admission. This arrangement gave the resident and or their family an opportunity to meet in person, provide information and assess or determine if the service could adequately meet the needs of each resident.

Residents had a comprehensive nursing assessment on admission. Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, falls and their skin integrity. In addition, an assessment of the level of cognitive impairment of residents admitted with a diagnosis of dementia was recorded and subject to review. The electronic system in place was designed to have all care needs assessed within a general care plan template. There were an additional four specific care plan templates in place. Improvement was required to ensure that when residents had specific care needs outside of the designed system that staff can easily document and retrieve this information to guide the care, for example, management of pain.

Inspectors examined pressure area care and wound management. From the files examined it was evident that practices relating to pressure sore prevention and wound

care could be improved. The new management team had targeted pressure care and wound care as an area for improvement. There was clear evidence from the documentation that pressure sore prevention and wound management had been revised and improvements in practice had resulted in positive outcomes for residents.

Arrangements were in place to routinely evaluate existing care plans on a four monthly basis. Overall the care plans reviewed were updated or revised to reflect the residents' changing care needs. Evidence that residents and or family, where appropriate, participated in care plan development and review was not available. This action is restated.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to a general practitioner (GP) and allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability, dental, ophthalmology and podiatry services were available.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services. 'End-of-life' care plans were documented in all files. Care plans reviewed included residents' expressed preferences regarding their preferred setting for delivery of care at the end-of-life. The resuscitation status of all residents was clearly recorded and all staff spoken to knew how to access this information in the event of a cardiac arrest. The centre has capacity to accommodate family and friends who wish to stay overnight within the centre.

Staff outlined how religious and cultural practices were facilitated within the centre. Residents were satisfied with the arrangements in place. The centre has an oratory which residents used throughout the two day inspection.

There were systems in place to ensure residents' nutritional needs were accessed, and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Procedures and care plans were in place in relation to nutritional care.

The inspector saw that a choice of meals was offered and available to residents. There was the system of communication between nursing and catering staff to support residents with special dietary requirements. The inspector was told by the chef on duty that the menu had been subject to review by a dietician. The menu choice was served on a four-week cycle.

Dining arrangements were set up in one large dining room. Staff provided encouragement or assistance to residents at the breakfast and lunchtime meal observed. The catering staff were familiar with the likes and dislikes of all of the residents. Inspectors were informed that a resident satisfaction survey is conducted two days per week. The catering staff had pictures of the food choices on offer for all residents to choose from. Overall the feedback from residents was very positive on the standard of food within the centre.

Residents had access to a pharmacist and GP of their choice. Residents were protected

by medication practices and procedures found. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents that were implemented in practice. Medicine administration records were maintained in accordance with relevant professional guidelines.

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
The centre had policies dated August 2017 in place to protect residents from suffering abuse and to respond to allegations, disclosures and suspicions of abuse. All staff had received training on identifying and responding to elder abuse. Staff were knowledgeable about the topic of abuse and staff spoken to were clear about who they would report any concerns too. Residents felt safe within the centre.

The centre had a policy dated August 2017 on the procedures in place to support staff in working with residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice. Staff spoken with adopted a positive, person-centred approach towards the management of responsive behaviours. The policy required review as the practice and documentation that was in place to guide staff was not reflective of what occurred in practice. Inspectors examined the care plan in place for a resident who exhibited responsive behaviours. The care plan did not contain sufficient detail to guide care and did not reflect the good practice which inspectors observed. Staff interactions observed were positive, sensitive, patient and staff displayed good knowledge of the residents.

The centre promoted a restraint-free environment. Additional equipment to reduce the use of restraint such as low level beds and sensor alarms were available. The were no residents using bedrails within this centre at the time of the inspection.

Systems and arrangements were in place for safeguarding residents' finances and property which met the requirements of the regulations. The accounting process was demonstrated to the inspectors by staff. The procedures and processes for safeguarding residents' finances were clear and transparent. The centre was a pension agent for one resident. The administration staff confirmed that the management of residents' pensions is in line with the Department of Social protection guidelines. Procedures were in place to facilitate residents to access their money when required.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
The provision of activities did not meet the needs of residents, particularly those with dementia. The activity co-ordinator role had recently become vacant in the centre and two staff were temporarily carrying out these duties. The management team informed inspectors that an activity co-ordinator was currently being sought to fill this vacancy. While inspectors acknowledged that this arrangement may temporarily impact upon the quality and quantity of activities provided, it must be noted that in the three inspections that have taken place since June 2017, inspectors have identified issues in relation to the provision of activities. Based on evidence gathered in this inspection, inspectors formed the view that the location and provision of activities was dictated by the routine and resources of the centre, not by residents' interests and suitability:
*Inspectors observed that on several occasions throughout the inspection, one staff member was responsible for providing activities to a large group of residents in the communal sitting room, while also supervising residents in this room, the adjacent smaller sitting room and the reception area. Therefore, when residents in these areas required assistance, activities were interrupted. Other staff were attending to other tasks and therefore were unable to consistently provide support or assistance during these times
*While the staff member responsible for activities informed inspectors that their role was solely to provide activities, they were observed carrying out other tasks on a number of occasions
*Of the six residents with dementia whose care plans were reviewed only two of these residents had activity assessments completed while three had their life histories documented
*Records of the activities completed by residents were sometimes documented, but the level of engagement was not recorded. Due to gaps in these records and the activity care plans, it was difficult to ascertain how residents' preferences or abilities informed the activities provided.

A 'health and wellbeing' audit completed in March 2018 had identified issues in relation to the provision of activities. Of the nine areas identified as 'not compliant', eight of these related to activity provision. Additionally, non-compliances relating to the role of activity staff had been identified at the previous two inspections of this centre. While action plans had been submitted by the registered provider in response to these non-

compliances, these non-compliances will be restated in this report. While the person in charge outlined future plans in place to enhance social care for residents in the centre, due to the ongoing impact of poor activity provision on residents since June 2017, a major non-compliance was warranted for this outcome.

While there was evidence that efforts were made to respect residents' privacy and dignity, and consult with them in relation to the centre, further improvement was required. Residents' forum meetings took place monthly and in addition to these, relatives' meetings also took place once every quarter. Minutes of these meetings indicated that there was a high level of attendance and a variety of topics were discussed, including activities, upcoming events and plans for the centre. The person in charge outlined how a text service had been set up to issue communications to residents' families when required. Inspectors noted that plans to consult with residents or relatives in the review of care plans had been discussed in recent meetings, but this had not taken place at the time of the inspection. This is actioned under Outcome 1, Health and Social Care Needs. A number of satisfaction surveys were issued to both residents and relatives on a regular basis, with 19 completed surveys received from residents since January 2018. A review of completed surveys emphasised that substantial improvements in the service provided had been experienced by residents since the beginning of 2018, with the majority of responses being positive in nature.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record these interactions at five minute intervals in a dining-room, large communal sitting room and smaller sitting room. Scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the quality of the interactions with the majority of residents. Inspectors' observations concluded that, for the most part, task orientated care was provided to residents by staff, with some instances of positive connective care also observed.

A secure courtyard was accessible from the large sitting room. The person in charge described plans in progress to purchase garden furniture and landscape the area to optimise use of this space during the summer months.

Residents' communication care needs were assessed and documented in care plans. Staff were aware of each resident's communication needs, particularly the needs of residents with dementia.

There was an open visiting policy in place, and inspectors observed friends and relatives visiting throughout the inspection. A 'protected mealtimes' initiative was in place, but the person in charge also described how residents could take their meals in the company of visitors in a more private area if they wished to do so.

Residents could keep up to date on local news from their community. Wireless internet was accessible to residents, who could also avail of a number of laptop computers in the centre. Portable telephone handsets were available for residents as required.

Independent advocacy services were accessible to residents, and residents could be supported to engage with these services if required.

Residents were facilitated to exercise their civil, political and religious rights. Residents were supported to vote in the centre and arrangements had been made to facilitate voting for the upcoming referendum. Residents of the various faiths could practice their religions. Residents had access to an oratory in the centre, and a local priest visited frequently to carry out religious services.

Judgment:
Non Compliant - Major

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
There were policies and procedures in place to inform the management of complaints in the centre. Residents who spoke with inspectors confirmed they knew they could express any dissatisfaction they had with the service and they felt they would be listened to.

There was a nominated person to investigate and manage complaints. Verbal and written complaints were recorded in a complaints log that was maintained in the centre. Inspectors reviewed this log and found that it contained the information required by the regulations. Complaints were found to be addressed and resolved in a timely manner, and the satisfaction of complainants with the outcome of their complaint was recorded.

A second person was nominated to ensure that all complaints were appropriately recorded and responded to, and there was evidence that complaints were being reviewed in this manner.

An appeals process was outlined for any complainants that were unsatisfied with the outcome of their complaints.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
While actions in relation to staff supervision and training had been completed since the previous inspection, the final action in relation to the provision of an appropriate number and skill mix of staff is restated at this inspection. Inspectors recommended a review of staffing for the following reasons:
*The non-compliances relating to activity provision, as outlined in Outcome 3
*Throughout the two days of the inspection, inspectors spoke with a number of residents who expressed concern about staff's ability to meet particular care needs in a timely manner. A review of surveys submitted by relatives in 2018 indicated that a small number of surveys echoed this concern.
*Inspectors observed a number of occasions throughout the inspection where there were unacceptable delays in responding to residents' requests for assistance
*Inadequate supervision arrangements in place for residents throughout the day. Large numbers of residents congregated in one communal room were supervised by one staff member for sustained periods of time.

A planned and actual staff rota was in place, with changes clearly indicated. The roster reviewed by inspectors reflected the staff on-duty on the day of inspection. One new member of staff was undergoing role induction at the time of the inspection. Since the previous inspection a number of senior care staff had been appointed; these staff were responsible for appropriately allocating care staff to tasks and supervising staff throughout each shift.

There were policies and procedures in place to inform staff recruitment, training and development. A comprehensive induction process, including adequate training, was in place for newly-recruited staff. The person in charge informed inspectors that probation assessments were completed throughout the induction process. An annual appraisal process was in progress and inspectors saw evidence of those that had been completed this year.

A sample of staff files were reviewed by inspectors, and these were found to contain all of the information required by Schedule 2 of the regulations, including evidence of completed An Garda Síochána Vetting. All staff nurses had up-to-date professional registration with An Bord Altranais agus Cnáimhseachais na hÉireann.

A staff training programme was in place. An action related the provision of training in moving and handling practices had been completed. Staff training records indicated that mandatory training requirements were facilitated and that staff were also supported to attend training to support their professional development. Staff who spoke with inspectors were able to confirm the training that they had completed and describe this training in detail.

Minutes made available to inspectors confirmed that the person in charge met various

staff grades on a quarterly basis, or more frequently if required.

A number of volunteers were operating in the centre at the time of the inspection. An Garda Síochána Vetting disclosures were in place for these volunteers and their roles and responsibilities were set out in writing.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
While progress had been made regarding upgrade works to the premises, further improvement was required to ensure that the design and layout of the premises was suitable for it's stated purpose and met the residents individual and collective needs.

As outlined in the previous inspection, a repainting project had been carried out in some corridors and in the reception area. This had enhanced the environment to make it brighter and more inviting. Inspectors noted that a number of residents now chose to spend part of their day seated in this newly-refurbished reception area. Since the previous inspection, a room had been converted to provide appropriate smoking facilities for residents. The person in charge had informed inspectors that two walkabouts of the building had been carried out since January 2018 and plans were being developed to address the following environmental issues:
*Five bedrooms on each wing were to be upgraded
*The assisted bath was out of order and required replacement
*Landscaping maintenance and garden furniture were required for a large internal courtyard that was accessible from the communal sitting room. The person in charge confirmed that garden furniture would be delivered in the week following the inspection
*The sink in the hairdresser's room was not suitable for use by a number of residents and required replacement. Plans were also in place to create a seating area outside the room and install a wall-mounted hairdryer
*Further minor upgrades such as wallpaper in corridors and blinds in the communal sitting room.

At the time of the inspection, the centre's management team could not provide a timeline of completion for these works. Inspectors expressed concern that the absence of a working bath did not support residents' choice in terms of meeting their personal hygiene needs. In the feedback meeting, the management team agreed to address these issues in the action plan response for this report. On the first day of inspection,

inspectors found that two of the four showers rooms in the centre had been decommissioned in order to provide additional storage for equipment. Consequently there were only two showers operational to meet the needs of 29 residents. Once brought to the attention of management the four shower rooms were made operational by the second day of the inspection. However, insufficient storage space for the assistive equipment was an ongoing issue.

Efforts had been made to ensure that the environment met the needs of residents with dementia. Signage was displayed to identify communal rooms, bedrooms and toilets. Some residents had chosen to decorate their rooms with small furnishing and other personal objects. The layout of the building supported the freedom of movement for residents. Handrails were available throughout corridors to support residents to navigate the building, and grab rails were in place in showers and toilets. The use of contrasting colours would further enhance the environment for residents with dementia.

One large communal sitting room and a smaller room were available for residents. An activity room which was used regularly by residents also served as a private room for GP (general practitioner) consultations. An oratory was also located in the centre, and was observed to be used by residents throughout the inspection.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

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

Findings:
Improvement was required in relation to the working order of a number of fire doors and some practices that presented infection control risks. Inspectors noted when walking along the corridor that a number of the bedroom fire door magnetic closing system were not closing. This was brought to the attention of the person in charge and also discussed at the feedback meeting. Immediate action was taken by the management team to resolve the issue and HIQA received confirmation that the fire doors are now all functioning.

Overall the premises, including the communal areas and bedrooms were found to be clean and there was an adequate standard of general hygiene maintained in the centre. All hand-washing facilities had liquid soap. There were policies in place on infection prevention and control. There was personal protective equipment such as latex gloves and plastic aprons available. Staff interviewed demonstrated adequate knowledge of the correct procedures to be followed. Cleaning staff were knowledgeable on the cleaning

schedule and the colour-coded cloth system in place. Inspectors observed that a infection control spillage was not attended too in a timely manner. The cleaning staff were not informed to ensure that the risk associated with cross infection and falls risk were minimised. The operational layout and design of the centre only has one sluice room. Inspectors noted that residents with known infection reside in both corridors. This meant that infectious waste has to be transported through the main reception area for disposal. This was also discussed with the management team for review of practices.

There was a risk management policy as set out in Schedule 5 of the regulations and included all of the requirements of regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. Inspectors reviewed the risk register maintained by the person in charge. This document was kept live. The person in charge had good oversight of all individual resident risk within the centre, for example, inspectors found that individual smoking risk assessments were completed for all residents who smoked and appropriate safety measures were in place. However, inspectors were concerned that operational risks brought to the management's attention during the inspection had not been identified or documented on the risk register. For example, access to an appropriate number of functioning showers to meet current resident needs.

The fire policies and procedures were centre-specific and the fire safety plan was viewed by inspectors and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. All staff had completed up-to-date fire training and those who spoke with inspectors could outline what action to take in the event of a fire. A number of fire drills had recently been completed, and records of these detailed the amount of time taken to complete each drill, the staff who were involved and any resulting learning or actions. Each resident had an up to date personal emergency evacuation plan (PEEP) in their bedrooms to guide staff.

Inspectors examined the fire safety register which evidenced that services and fire safety tests were carried out in line with requirements. Emergency lighting throughout the centre was tested. Daily check of fire exits and escape routes were carried out.

Judgment:
Non Compliant - Major

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:

Since the previous inspection there has been a significant change in the management team in the centre. The newly appointed person in charge displayed good knowledge of the regulations. The person in charge is supported by a newly appointed clinical nurse manager, who will also deputise in an absence of the person in charge. The clinical nurse manager displayed very good knowledge of the current residents within the centre. The residents who spoke with inspectors were aware of the changes and knew the new person in charge by name. This was a unannounced inspection and the inspectors found that all data requested was easily retrieved by the person in charge.

The management team had good knowledge of the findings from the previous inspection in December 2017, and associated action plan responses. Four of the 14 actions from the previous inspection had not been adequately progressed:
*The requirement to put management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This is supported by the non compliance found across multiple outcomes.
*The management teams failed to identify and mitigate local operational risks
*Care plan development and consultation with the resident or relatives.
*The ongoing non-compliance found under Outcome 3, Residents' rights, dignity and consultation with specific reference to ensuring that opportunities for residents to participate in activities in accordance with their interests and capacities are met.

As stated in the summary, this inspection was a triggered inspection following receipt of unsolicited information of concern. Inspectors found evidence that the concerns about wound management were partially substantiated. Inspectors acknowledge that the allegations made were logged within the complaints log and the person in charge was following the local policy on complaints' management which is in line with best practice guidelines.

The new management support structure in place is comprehensive. Inspectors acknowledge that there was a willingness to ensure that the centre addresses all gaps to bring the centre into full compliance with the regulations. There was some progress made in the development of systems to ensure that the service provided was monitored and safe, but further improvement was required.

Clear lines of accountability and authority were evident in the centre. Inspectors found that the new management team was collating monthly clinical data, and key clinical parameters were audited since the last inspection. The data collated was analysed and action plans were developed to inform areas requiring improvement. Additionally, policies and procedures were in place to guide practice and service provision.

An annual review of the quality and safety of care delivered to residents for 2017 was completed.

Judgment:
Non Compliant - Moderate

Outcome 10: Suitable Person in Charge

Theme:
Governance, Leadership and Management

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

Findings:
The centre was managed by a suitably qualified and experienced nurse who is in position since January 2018. The person in charge had a strong presence within the centre and was known to the residents and families. She held authority, accountability and responsibility for the provision of the service. The person in charge had progressed the action plan from the last inspection and there was clear evidence of the positive impact this was having on the centre.

The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions and was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents. During the inspection she clearly demonstrated that she had sufficient knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre.

The residents and relatives spoken to throughout the two day inspection were knowledgeable about who the person in charge was and voiced that they would have no hesitation in bringing any issues to her attention. In addition the staff voiced full confidence that any complaint made would be appropriately followed up.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Leanne Crowe
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Regulation Directorate
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Action Plan

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

Provider's response to inspection report[1]

Centre name:	St Colmcille's Nursing Home
Centre ID:	OSV-0005531
Date of inspection:	10 & 11 May 2018
Date of response:	07 June 2018

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:
Evidence that residents and or family, where appropriate, participated in care plan development and review was not available.

1. 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

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

family.

Please state the actions you have taken or are planning to take:
We will ensure that residents and their relatives, where appropriate have an opportunity to participate in care plan development. A record of the consultation will be documented in the resident's care plan.

Proposed Timescale: 08/06/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that when residents had specific care needs outside of the designed system that staff can easily document and retrieve this information to guide the care.

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

Please state the actions you have taken or are planning to take:
The Person in Charge will undertake pre-admission assessments on all residents referred to the centre where possible. A comprehensive care plan will be developed in consultation with the resident and/or family member where appropriate and this will address how all aspects of care will be met, based on the assessments and resident's preferences and wishes. The current electronic care planning system will be upgraded to enable all specific care needs to be addressed in sufficient detail.

Proposed Timescale: 31/10/2018

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The policy for the management of responsive behaviours required review as the practice and documentation that was in place to guide staff was not reflective of what occurred in practice.

A care plan for responsive behaviours did not contain sufficient detail to guide staff.

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

Please state the actions you have taken or are planning to take:
The management of behavioural and psychological symptoms is guided by the centre's policy, which identifies the indications for use of an Antecedent, Behaviour and Consequence (ABC) chart. The ABC chart is the preferred tool used in assessing and recording behavioural and psychological symptoms displayed and has been introduced for the resident concerned.
Residents who display behavioural and psychological symptoms now have appropriate care plans in place with sufficient detail to inform staff of the individual needs of each resident.

Proposed Timescale: 08/06/2018

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To provide opportunities for residents to participate in activities in accordance with their interests and capacities, including ensuring that the role of the activity co-ordinator can dedicate their time to providing activities for all residents, including those with dementia.

4. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
The role of the Activities Coordinator was vacant at the time of inspection; a suitable candidate has been appointed and is expected to commence in post on 11/06/2018, subject to satisfactory Garda Vetting. The aim of the newly appointed Activity Coordinator will be to implement an individual programme of activities for each resident. They will also assist staff in providing opportunities for residents to allow them to participate in activities in accordance with their expressed interests and capabilities.

Proposed Timescale: 30/07/2018

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Ensure that the number and skill mix of staff is appropriate to meet the needs of residents, and for the size and layout of the centre.

5. 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:
Regular staffing reviews are completed to ensure that the number and skill mix of staff is appropriate to meet the assessed care needs of residents, based on the number of residents, their dependency levels and taking into account the size and layout of the centre. Consideration is also given to any other factors that may be identified as having an impact on the daily operation of the centre.

Proposed Timescale: 08/06/2018

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Ensure that the premises meet the requirements of Schedule 6 of the regulations.

6. 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:
A planned programme of refurbishment and extensive decorative works is in progress to improve the environment for residents and to ensure that the premises meets the requirements of Schedule 6 of the Regulations.

Proposed Timescale: 30/09/2018

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory

requirement in the following respect:
Inspectors were concerned that operational risks brought to the management's attention during the inspection had not been identified or documented on the risk register.

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:
A full review of the risk register has been completed. Individual risk assessments are in place. Identified operational risks have been added to the risk register. Risks will be regularly reviewed and monitored as part of the monthly Quality and Safety meetings in the centre.

Proposed Timescale: 08/06/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The operational layout and design of the centre only has one sluice room. Inspectors noted that residents with known infection reside in both corridors. This meant that infectious waste has to be transported through the main reception area for disposal.

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:
All staff have completed training in Infection Prevention and Control. Residents with a known infection have a care plan in place reflecting their individual care needs and treatment in relation to the control of infection. An organisational risk assessment is in place to highlight measures in place to reduce and prevent cross infection.

Proposed Timescale: 08/06/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors noted when walking along the corridor that a number of the bedroom fire door magnetic closing system were not closing.

9. Action Required:
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
In line with fire safety precautions in designated centres for older persons a full review of all doors has been completed and all doors are now in full working order.

Proposed Timescale: 07/06/2018

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Four of the 14 actions from the previous inspection had not been adequately progressed.
-The requirement to ensuring that the management systems in place ensure that the service provided was safe, appropriate, consistent and effectively monitored. This is supported by the non compliance found across multiple outcomes.
-The managements inability to identify and mitigate local operational risks.
-Care plan development and consultation with the resident or where appropriate the relative.
-The ongoing non compliance found under Residents rights, dignity and consultation with specific reference to ensuring that opportunities for residents to participate in activities in accordance with their interests and capacities are met.

10. 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:
There is a clearly defined management structure in place and this reflects the information outlined in the centre's Statement of Purpose. Lines of authority and accountability are clearly defined and all members of the team are aware of their roles, responsibilities and their reporting procedures.
There are monitoring systems in place which comprehensively inform the provision of a high standard of care and continuous quality improvement in the centre:
The Person in Charge (PIC) completes a weekly report which is a review of all aspects of quality, safety, capacity and capability. This report enables her to examine and respond to any anomalies, risks or hazards in relation to the safe operation of the centre. The Provider receives this report. Management team meetings are held on a monthly basis and are attended by the heads of department, the PIC, the Clinical Nurse Manager and the Healthcare Manager. All aspects of the quality and safety of care and

service are discussed at these forums. An action register is completed, based on quality improvements required.

A full review of the risk register has been completed. Individual risk assessments are in place. Identified operational risks have been added to the risk register. Risks will be reviewed as part of the centre's monthly Quality and Safety meetings.

A schedule has been put in place to ensure that residents and their relatives have an opportunity to participate in care plan development.
Residents have actively engaged with this process and relatives have been invited to be involved in the development of care plans where appropriate.

In order to ensure that residents have opportunities to participate in meaningful social activities in accordance with their expressed interests, preferences and capacity, a new Activities Coordinator has been appointed. We will ensure that the range and schedule of activities is varied and person-centred.

Proposed Timescale: 30/07/2018