

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Sacred Heart Nursing Home
Centre ID:	OSV-0005557
Centre address:	Crosspatrick, Johnstown, Kilkenny.
Telephone number:	056 883 1318
Email address:	sacredheartnursinghome@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sacred Heart Nursing Home Limited
Provider Nominee:	Sacred Heart Nursing Home Limited
Lead inspector:	Ide Cronin
Support inspector(s):	Mary O'Donnell
Type of inspection	Unannounced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	14

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was following receipt of unsolicited information. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 10 November 2017 06:40 To: 10 November 2017 16:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This unannounced inspection was triggered following receipt of unsolicited information by the Health Information and Quality Authority (HIQA). These concerns alleged issues in relation to institutional practices, inadequate staffing, management of complaints, staff communication and end-of-life care. Inspectors focused on lines of enquiry in relation to the unsolicited information. Inspectors followed up on the one action from the previous inspection and found that this action had been completed.

On arrival to the centre, inspectors met with the night staff and some residents. Inspectors also met and spoke with residents, a relative and staff during the day. Residents and a relative who spoke with inspectors were complimentary of the staff group and expressed overall satisfaction with the care received.

A major non-compliance was merited in relation to Outcome 7: Safeguarding and Safety. Findings on this inspection did not provide adequate assurances that residents with responsive behaviours were appropriately supported and managed and as such posed a risk to the welfare of other residents and staff. This was discussed in detail with the provider and person in charge.

A major non-compliance was also merited in relation to Outcome 18: Staffing.

Inspection findings did not provide assurances that the staffing levels and skill-mix complement met the assessed needs of 35 residents. Inadequate staffing impacted on the supervision of residents and the provision of person-centred care. It also posed a risk to the safety and welfare of residents. Staffing arrangements were not in place as described in the statement of purpose. The impact of the staffing levels also resulted in the statement of purpose not being fully implemented in practice.

Major non-compliances were found within Outcome 2: Governance and Management with evidence that the management arrangements were not sufficiently robust to assure the quality and safety of the service on a consistent basis. As a result of the inspection findings and issues highlighted within the unsolicited information received, the provider was requested to submit a plan by 15 November 2017 to demonstrate how deficiencies identified on the day of inspection would be rectified.

The findings and improvements required are discussed within the body of this report and set out 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 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:

A governance structure and reporting mechanisms were in place for this centre and a clearly defined management structure was outlined in the statement of purpose. Inspection findings supported a requirement for improvement in the governance and management of the centre to ensure the service was adequately resourced and the needs of residents were met in line with its stated purpose.

The inspectors found that there was an organisational structure in place. However, significant improvements regarding management systems were required to ensure compliance with the regulations and to provide assurances to the Chief Inspector that the centre was being efficiently governed; ensuring residents were being delivered a service that was safe, effective and met their needs.

Staff responsibility and accountability for practice and service delivery was also in need of improvement to ensure all areas of care provision were suitably governed and managed in accordance with the aims and objectives of the statement of purpose. Staffing arrangements were not in place as described in the statement of purpose.

The staff resources and roster for the previous two weeks was reviewed by inspectors. The roster also showed that persons participating in management worked from Monday to Friday. It showed the person in charge worked five days per week. A member of the management team who facilitated activities and occupational therapy for residents was not rostered, therefore it was not possible to determine if the hours worked correlated with the statement of purpose.

Inspectors confirmed that some staff worked night duty mainly. Day time staffing levels were inadequate to meet the complex care needs of some residents as evidenced through review of documentation, speaking with residents and staff and observations by

inspectors. This is further detailed under Outcome 18: Staffing

The need to review and improve the supervision and oversight of all staff including those on night duty required improvement to ensure the delivery of care was safe, appropriate and monitored on a consistent basis. Inspectors concluded that the staffing levels, arrangements and resources available at the time of this inspection did not support staff to effectively exercise their personal, professional and collective accountability for the provision of effective and safe care.

Information governance also required improvement particularly in relation to clinical recording practices by staff. For example, staff had not maintained contemporaneous records and had reported on resident outcomes two hours and ten minutes in advance of their shift ending. Staff involved had not completed a comprehensive record of their findings, response or actions taken following a significant incident which involved emergency response services.

The arrangements for the review of incidents within the centre required significant improvement. There was insufficient evidence found to demonstrate sufficient or robust arrangements available for the identification, recording, investigation and learning from a near-miss, serious incidents or adverse events involving residents and staff. Inspectors concluded that residents and staff were not protected by practices that promote safety. Inspectors saw that where incidents occurred the management team had not taken all reasonable and proportionate measures to protect residents and staff.

Overall, it was not demonstrated to inspectors that there was a clear commitment to promoting and strengthening a culture of quality and safety for residents and staff. It was not demonstrated that sufficient resources were deployed to adequately meet the needs of all residents to ensure a person centered, safe and effective service. Therefore inspectors requested a plan to be submitted to the Chief Inspector by 15 November 2017 to address staffing resources and risk management processes to ensure resident and staff safety.

Judgment:

Non Compliant - Major

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:

Inspectors found that there were insufficient safeguards in place to protect residents from verbal and physical aggression. Although no injuries were sustained, inspectors found evidence of several incidents where residents were verbally and sometimes physically aggressive towards other residents. Residents with responsive behaviours shared bedroom accommodation with other residents and residents who spoke with inspectors described strategies they used to keep safe. Residents witnessed staff being verbally abused and sometimes physically assaulted in communal areas. Inspectors were concerned that there were insufficient safeguards including staff in place to support residents who had behavioural issues and to keep other residents and staff safe. The accommodation offered to residents with responsive behaviours and the level of supervision was not adequate. This was discussed in detail at the feedback with the provider nominee and the person in charge.

Inspectors saw that there were no systems in place for systematically identifying aspects of service delivery that may be associated with the risk of harm to residents and staff. Near misses were not documented and incident forms were not consistently completed following these incidents. Staff said there was no benefit to reporting incidents as nothing changed. Incidents were not analysed for the purposes of learning and there was no prompt and effective dissemination of learning from the management team following incidents/adverse events.

Judgment:

Non Compliant - Major

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:

The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. However, inspectors observed that all notifiable incidents had not been notified to the Chief Inspector as required by the regulations.

Judgment:

Non Compliant - Moderate

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:

There were suitable arrangements in place to meet the healthcare needs of residents. Inspectors found that improvement was required so that each resident's wellbeing and welfare was maintained by appropriate evidence-based nursing and allied health care.

Residents had access to general practitioners (GPs) of their choice, and to allied healthcare professionals including dietetic, speech and language, dental, ophthalmology, and occupational therapy and podiatry services. Residents also had access to psychiatry of later life services. Improvement was required to ensure that all residents availed of these services. Inspectors observed that a resident, whose toe nails and feet required attention, had not accessed podiatry services since January 2017. The person in charge explained that the podiatrist was on site every three months but the resident refused the service. There was no documentary evidence that the service was offered and refused or that alternative plans had been considered to meet the resident's needs.

Samples of clinical documentation including nursing and medical records were reviewed which indicated that all recent admissions to the centre were assessed prior to admission. The pre admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident. However, in view of the findings under Outcome 7, inspectors questioned if the pre admission assessment was sufficiently robust to ensure that the centre could meet the needs of residents with responsive behaviors (a term used to describe how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

A care plan was developed within 48 hours of admission based on the resident's assessed needs. Inspectors also noted that care plans were reviewed following consultation with the resident or, where appropriate, their relative. However, improvement was required to ensure that the care plans were sufficiently detailed and actually implemented. Daily care records and nursing notes were not completed contemporaneously and the residents name was not stated on each page. Inspectors found it was not possible to determine from the daily nursing records if or how a resident's personal hygiene and dental care needs were met. Inspectors observed that a number of residents with constipation took laxatives and the high fibre foods itemised in their care plan were not served at breakfast. Catering staff confirmed that they were not in stock.

Inspectors found that improvement was required to ensure that residents' nutritional needs were met. Weights were recorded for all residents on a regular basis. Validated nutritional assessment tools were used to identify residents at potential risk of

malnutrition or dehydration on admission and were regularly reviewed thereafter. However, inspectors were not assured that action was taken whenever nutritional risk was identified. In the case of a resident who had unintentional weight loss and was assessed as being at risk of malnutrition on 1 Oct 2017, no action had been taken. The nurses written comment 'on supplements' was not accurate, as the nurse on duty told the inspector that the prescription for nutritional supplements had been discontinued when the entry was made. The resident had not been referred for dietetic review and there was no food intake chart introduced, in line with the local policy. The system of communication between nursing and catering staff required improvement to support residents with special dietary requirements. Catering staff when interviewed were not aware that one resident required a high protein diet or that some residents required a high fibre diet.

Inspectors saw that residents who required their meals in a modified consistency had the same choices available to them as other residents.

Residents with diabetes were appropriately monitored and managed. Inspectors found the staff who undertook the procedure of blood glucose monitoring adhered to HIQA guidance in relation to blood glucose monitoring. Residents with diabetes were managed by the GP and referred to the diabetic clinic where appropriate.

Inspectors reviewed wound management practices and saw that wound assessment and treatment charts were in place and residents had access to the services of a tissue viability nurse and acute hospital services when required.

Residents were regularly assessed for risk of falls. Care plans were in place when risks were identified and the risk assessments were revised regularly. Care plans were updated to include interventions to mitigate the risk of falls.

Staff spoken with confirmed that the centre received support and advice from the local palliative care team. The 'Think Ahead' document was used to support residents and family members to plan for future care. Inspectors saw that residents were offered the opportunity to outline their wishes regarding end-of-life care. Improvement was required in relation to communications within the staff team. There was evidence that end-of-life plans were not consistently implemented as some staff did not know the end-of-life wishes for residents in relation to resuscitation.

Inspectors were satisfied that medicine management practices were safe. Having reviewed a sample of completed prescription and administration records, inspectors found they were in line with best practice guidelines. Written evidence was available that three-monthly reviews were carried out.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and

homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

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

Findings:

Inspectors observed that following the last inspection a clear glass panel had been inserted into the door of the smoking room. This enabled staff to observe residents while they smoked.

The new extension did not include a dining facility and the two existing dining rooms were situated some distance from the new accommodation. Inspectors observed that the two dining rooms could accommodate a maximum of 21 residents and this did not include residents in specialist seating who required additional space. There were two sittings at meal times.

The inspector raised this issue with the registered provider on the inspection of 4 October 2017. The registered provider proposed various options which they would consider to address this.

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 inspectors saw that there were policies, procedures and systems in place for the management of complaints. Inspectors saw that the most recent complaint had been logged on 29 December 2016. This issue had been recorded as resolved to the satisfaction of the complainant.

However, the unsolicited information received referenced that relatives had made complaints which had not been addressed. The person in charge told inspectors that

complaints were not logged if they were resolved when they are raised verbally. Inspectors also noted that concerns/complaints raised by staff were not documented.

Inspectors did not find documentary evidence that all complaints were investigated promptly. The systems in place did not 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

Judgment:

Non Compliant - Moderate

*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:

Inspectors were not assured that residents were facilitated to exercise their choice and control over their lives and to maximise their independence. The findings from this inspection do not evidence that all residents, had opportunities to participate in meaningful activities in line with their capabilities, interests and preferences.

The activity co-ordinator usually provided an activity programme to residents in the morning and in the afternoon. The social assessment provided a biographical history and information on each resident likes and dislikes which was generally used to inform activity provision. Residents were supported to attend events in the community and to go on trips with the provider or with relatives and friends. Inspectors observed group activities and someone to one activities in the day room. While inspectors acknowledge that the activity co-ordinator was on holiday on the day of the inspection, there did not appear to be an adequate system in place to ensure residents engaged in activities while the activity co-ordinator was not working. Some less able residents spent periods in their room and while staff were extremely courteous when interacting with these residents, the interaction usually related to the completion of a care task rather than to meet residents' social needs.

Institutional practices such as serving breakfast to 18 named residents before 08:00hrs am did not reflect a person-centred approach to care. While acknowledging that at least three residents liked an early breakfast, the majority of residents who spoke with inspectors did not request an early breakfast but felt it was a necessary part of the daily routine. One resident whose care plan stated that they liked breakfast at 10:00hrs was

served breakfast at 07:30hrs. Staff on night duty worked from a list which detailed the time when each resident had breakfast and they identified residents who they were expected to have up and dressed before the day staff came on duty. Some residents were content to get up early but others complained that it was too early to have to get up. This finding did not reflect a high standard of person-centred care that respected residents' rights.

The screening of shared rooms had been fitted to ensure that each resident is facilitated to undertake personal activities in private.

Residents had access to daily newspapers, radio and television. They had access to a private telephone and could meet with visitors in private. Staff outlined the arrangements in place to facilitate residents to vote in the centre, and to exercise their religious rights.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

Only the line of enquiry in relation to staffing levels and skill mix was considered as part of this inspection. The findings of this inspection did not provide assurances that the staffing levels and skill-mix complement met the assessed needs of 35 residents, particularly residents with complex needs who had responsive behaviours. Inadequate staffing posed a significant risk to the safety and welfare of residents and staff.

Inspectors' observations throughout the day of the inspection indicated that staffing levels were not sufficient to provide person-centred nursing and social care, or to adequately supervise residents. Inspectors observed several instances where two staff were required to provide care but only one staff member was allocated to care for these residents. Unsafe practices were observed when one staff member transferred two residents from bed to chair using a hoist. The manual handling charts stated that these residents required two staff for this transfer. Staff said they were reluctant to ask a

colleague for assistance as they would be interrupting the care of another resident. In other cases residents who posed a risk of falling or a risk of violence and aggression to staff were attended to by a lone staff member. Inspectors found evidence that a number of staff had been assaulted but incident forms were not completed following these events.

It was not possible to determine how many staff hours were allocated to the provision of direct care, as care assistants were allocated to undertake cleaning and laundry duties in addition to the provision of care. Night staff reported that they did cleaning and laundry duties as well as preparing vegetable for the next day. They were also required to serve breakfasts and have a certain number of residents up and dressed before they went off duty. On the day of inspection there were three care assistants rostered on duty for the afternoon. However, inspectors were informed that one care staff replaced the activity co-ordinator who was on two weeks leave and was allocated to facilitate a group activity for residents. Another care staff was allocated to the laundry for that afternoon. Inspectors were informed that prior to the inspection a household staff member had left unexpectedly which impacted on service demands as observed by the inspectors. Inspectors saw that there was visible dust present in areas and there was a mal odour present in a corridor.

Inspectors concluded that healthcare assistants were deployed to cover leave and other duties as required by service demands as there were no contingency plans in place. These direct care hours allocated for residents were not replaced within the allocated staffing complement. Therefore caring hours provided to residents were depleted as staff carried out other duties.

The roster did not correlate with the staff on duty. For example a member of the management team was present on the day of inspection but not rostered on the roster. This staff member told the inspector that she was returning from leave that day and would often pop in and out of the centre to conduct an activity while she was on leave. However, rosters did not confirm this.

Inspectors saw that the roster commencing week of 30 October to 5 November 2017 there were no members of the management team on duty over the weekend and there were no on-call arrangements reflected on the roster.

On the previous inspection of 4 October 2017 the registered provider had agreed a staffing plan to increment all staffing grades in tandem with the admission of 13 new residents to the new extension. However, based on inspection findings on 10 November 2017 inspectors were not assured that staffing levels would be suitable and sufficient to meet the needs of residents if the occupancy levels were above 35. Other areas requiring review included the need to review the system in place regarding the length of time staff spent on night duty and supervision arrangements for that shift, as outlined in outcome 2.

Staff training records were not examined on this inspection but training in relation to the recording of clinical practice was required based on the inspection findings.

Inspectors found that staff supervision was of poor quality and did not improve practice

or accountability. The management team did not demonstrate an understanding of the risks and levels of need within their service, taking into account the views of residents and staff to inform planning and resource allocation. Inspectors also concluded that the staffing levels did not correlate with the staffing arrangements as outlined in the centre's statement of purpose.

The registered provider was requested to submit a plan by 15 November 2017 to demonstrate how these deficiencies identified on the day of inspection would be rectified to ensure the care and welfare of all residents and safety of staff.

Judgment:

Non Compliant - Major

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:

Ide Cronin
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:	Sacred Heart Nursing Home
Centre ID:	OSV-0005557
Date of inspection:	10/11/2017
Date of response:	07/12/2017

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non-compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The governance and management arrangements, processes and controls in place were insufficient to ensure the effective delivery of care in accordance with the statement of purpose

The staffing levels and whole time equivalent resources available at the time of inspection did not correlate with the statement of purpose and function.

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(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

The PIC will continue to work in a full-time supernumerary capacity. She is supported in her role by the provider nominee who works full time in the centre and to further strengthen the management team the senior OT (who has now returned from leave). She will assume the position of operations manager and will be working three days per week in the centre and will oversee and manage non-clinical areas which affords the PIC the time to focus more on clinical and direct care staff supervision, documentation and ensuring that the services delivered are safe and effective and can meet the needs of current residents.

The senior management team are currently reviewing their roles and supervisory responsibilities and will attend more formal governance meetings which are structured and will include agenda items such as; incidents/accidents, complaints, staffing levels, resources etc. The PIC will ensure that the duty rosters accurately reflect the management hours.

To improve the overall governance of the centre a full time ADON has been appointed who will work in a supernumerary capacity for 24 hours during the week. The ADON will have the authority to supervise and monitor staff. This allows for improved supervision of staff and care practices, additionally, a senior care assistant post has been created to further strengthen the management, supervisory and control measures within the centre.

Staffing levels have been increased. Four additional staff have been recruited, two care assistants who will only be involved in direct care and two housekeeping staff. Additionally, care hours have increased by three hours in the afternoon which ensures that there is no requirement for multi-tasking of laundry duties and in turn ensures that there are adequate direct care hours.

Moving forward the PIC will use a recognised ratio and acuity tool to support her in determining that staffing levels are safe and appropriate to meet the needs of current residents. This staffing level assessment will be completed monthly or sooner if there are changes for example change in residents' condition, new admissions or if residents return from hospital.

Proposed Timescale: 31/01/2018

Theme:

Governance, Leadership and Management

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

The management arrangements were not sufficiently robust to assure the service was safe, appropriate, consistent and effectively monitored to ensure the quality and safety of the service.

Arrangements for the supervision, monitoring and review of residents care and staff practice were inadequate.

Governance arrangements required improvement to ensure the delivery of care was safe, appropriate and monitored on a consistent basis to deliver quality care standards. The staff roster showed that persons participating in management worked from Monday to Friday and not at weekends or at night. The roster and staff confirmed that a number of staff mainly worked night duty. Rosters did not always reflect on call arrangements.

The arrangements for the recording and review of incidents within the centre required improvement. Gaps were found in the recording and management of and assessment details of incidents. Some assessments and clinical care did not consistently accord with evidence based practice,

A system to monitor staff practice, acts or omissions and/or and procedures carried out following a significant incident and change in a resident's condition required improvement.

2. 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:

As discussed above, the addition of the ADON supernumerary hours and the role of the operations manager will ensure that there is more time available for the supervision of residents and staff, and documentation etc.

The PIC is currently reviewing the incident reporting system. A new incident reporting form will be developed which will clearly guide staff into what is required in terms of reporting and allows the PIC to show evidence of post incident review and investigation. All nursing staff will have update training on incident reporting and the management of incidents/accidents.

The PIC and ADON will ensure that all incident and accident reports are seen within 24-48 hours and actioned appropriately. They will also on a weekly basis review all incident reports, carry out a root cause analysis on these, and ensure that there is evidence of regular patterning and trending so that they can identify areas of concern and put in place more proactive and robust systems to mitigate risk and address issues in a timely fashion.

Where for example ABC charts are being used to monitor residents with responsive behaviours these will be monitored daily, reviewed formally weekly to ensure that, where necessary, safeguarding plans are in place, appropriate referrals are made, and

staff are guided in how best to support residents. Additionally, all nurses will be instructed to record any changes in residents' behaviours, any obvious escalation in responsive behaviours (verbal or physical) and report these to the PIC/ADON.

All serious/untoward incidents, if they occur out of hours will be immediately reported to the on-call manager who will guide and support staff. Following any serious incident, the PIC and management team will undertake a full investigation to establish what happened and why, to determine if there were suitable guidelines in place if these were adhered to and to identify any new measures and controls that need to be put in place to reduce the risk of reoccurrence. This system will be reviewed after three months to determine if it is the most effective and efficient manner to manage incidents/accidents etc.

The management team are currently reviewing senior management cover on and off site, out of hours and weekends and will put in place a more formal on-call duty arrangement whereby staff will clearly be able to identify who is on call and they will also develop robust guidelines to support staff in the event of emergency or unforeseen situation. As part of the induction programme all staff will be made aware of these and all nurses will receive ongoing support from the PIC in relation to how they might guide staff and supervise junior staff during the course of their duties.

There will be increased management cover over the weekends. The ADON will be rostered on duty at least two weekends per month. The operations manager will be rostered on duty at least one weekend day per month. The Person in Charge will be rostered on duty at least one weekend day per month. The registered provider will be rostered on duty at least four weekend days per month.

The management team have spoken with the staff and agreed that to ensure safe practices, ongoing training and development, permanent night staff will rotate to day duty. Additionally, the PIC and ADON will carry out weekly supervisory visits at night, will ensure that there are regular staff meetings and the PIC will ensure that the ongoing audit programme continues, and the findings are used to improve systems, care practices etc.

Proposed Timescale: 31/01/2018

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:

The accommodation offered to residents with responsive behaviours and the level of supervision was not adequate.

There were no systems in place for systematically identifying aspects of service delivery that may be associated with the risk of harm to residents or other persons. Near misses

were not documented and incident forms were not consistently completed following these incidents. Incidents were not analysed for the purposes of learning and there was no prompt and effective dissemination of learning from the management team following incidents/adverse events.

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:

All residents who currently share rooms will have risk assessments undertaken to determine if this arrangement is safe, in keeping with the wants/wishes of the resident and to identify if residents present with responsive or any behaviours that could potentially impact on the safety and welfare of either resident in the room. If the risk assessment identifies that sharing a room is not in a resident's best interest, then single or alternative accommodation will be offered.

A review of the management of responsive behaviours will be undertaken to identify any possible system failures and from this an action plan can be developed to ensure that the system in place is safe and appropriate. Staff will be instructed to continue to use ABC Charts from which staff and the PIC will be able to identify triggers, consequences and behaviours which they will use to formulate appropriate plans of care. All residents who present with responsive behaviours are currently in the process of having MDT assessments, care plans will be reviewed to ensure that each care need identified is adequately addressed and an appropriate plan is in place.

Further staff training on responsive behaviours was provided on 29th November 2017. We will continue to debrief staff on the learning from specific incidents and will continue to review the appropriateness of placement for all residents presenting a risk. The PIC will arrange for a post training analysis to determine staffs understanding and knowledge of responsive behaviours to ensure that they have the necessary skills to appropriately and effectively support residents who present with behaviours that challenge. Should further needs be identified, further training will be arranged.

Proposed Timescale: 31/01/2018

Theme:

Safe care and support

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

Inspectors found evidence of several incidents where residents were verbally and sometimes physically aggressive towards other residents. Residents with responsive behaviours shared bedroom accommodation with other residents and residents who spoke with inspectors described strategies they used to keep safe. Residents witnessed staff being verbally abused and physically assaulted in communal areas.

4. 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:

Following the review of responsive behaviours, and the post training analysis, if necessary further training will be arranged for all staff with a view to ensuring that the training is specific to the centre and addresses issues and concerns that staff may raise. Shared room risk assessments to be completed for all residents. Staff have been advised to document and report all actual or near misses in terms of verbal or physical abuse or assaults targeted at residents or staff. The PIC and ADON will systematically and regularly review these using a system of root cause analysis and will ensure that appropriate actions are taken to mitigate or reduce risks. The PIC will as a part of the review of any incidents consider whether the centre can continue to meet the needs of residents and whether the resident's continued placement is appropriate and safe.

The PIC and ADON will carry out assessments on all residents to identify those residents with responsive behaviours and to develop appropriate safeguarding and care plans to support these residents and guide staff in how best to manage responsive behaviours.

Proposed Timescale:

Review of responsive behaviours – 18th January 2018

Post training analysis – 31st January 2018

Shared room risk assessments – 31st December 2018

Review of incident reports – immediate.

Responsive behaviour care plans – 28th February 2018

Proposed Timescale: 28/02/2018

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:

The Chief Inspector was not notified of the occurrence of a significant event within three days of its occurrence.

5. 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 Provider will ensure that in future all statutory notifications are submitted to the

Authority as required.

Proposed Timescale: 07/12/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Inspectors questioned if the preadmission assessment was sufficiently robust to ensure that the centre could meet the needs of residents with more complex health needs.

6. Action Required:

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

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

The admissions policy and criteria for admission will be reviewed. Where pre-admission assessment is requested for residents with more complex healthcare needs the PIC will undertake the assessment with support and input from either the operations manager or the ADON and will request reports from appropriate allied health professionals to assist the decision making as to whether the centre can meet the needs of the resident. If the proposed resident has been an inpatient or resident of another centre, a full report will be requested prior to the decision being made and with the resident's permission, family members will be contacted to see if they can offer further insights etc.

Prior to a decision being made, the PIC will take into consideration, the current resident group, to determine what, if any impact the decision will have on their safety and well-being. The PIC will consider the current staffing skill mix and knowledge base to determine if the centre has the appropriate skills and knowledge to meet the needs of the resident and to support their admission.

Where a resident is considered to present with more complex healthcare problems such as behaviours that challenge, the PIC will liaise with the Dept. of Psychiatry for Older People and establish a service level agreement prior to admission which would include regular reviews, visits and assessments.

Proposed Timescale: 31/12/2017

Theme:

Effective care and support

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

Inspectors were not assured that action was taken whenever nutritional risk was identified.

There was an ineffective system of communication between nursing and catering staff to support residents with special dietary requirements. Catering staff when interviewed were not aware that one resident required a high protein diet or that some residents required a high fibre diet.

7. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

A more formal system of communication will be put in place to ensure that the catering department have up to date and accurate knowledge of residents' needs. The PIC and chef will meet monthly to discuss residents with more complex needs or specialist diets etc. The PIC will ensure that the catering department is notified immediately of any changes to residents' dietary needs and is developing a new dietary requirement sheet, copies of which will be stored in the residents' care plan and catering records.

The PIC/ADON will ensure that the chef is updated as to the residents' needs following visits from the dietician or speech and language therapy. The PIC will ensure that as part of nutritional audits, information known and shared with the catering department is included.

The PIC will ensure that an audit of residents' current nutritional status (MUST and weight) is completed monthly so that those residents considered to be at high risk or with weight loss can be referred to dietetic services in a timely fashion.

Proposed Timescale: 31/03/2018

Theme:

Effective 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 the care plans were sufficiently detailed and implemented.

Improvement was required to ensure that information regarding the resuscitation status of each resident was available to all staff in an emergency.

8. 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 admissions policy will be reviewed and amended if needed to ensure that it guides the PIC, and/or any staff involved in the pre and post admission of a resident in how best to ensure that the placement is suitable and can meet the individual needs of the proposed resident, taking into consideration the residents already living within the centre.

The PIC will:

(i) carry out a risk assessment to identify if there are any additional concerns, medical illnesses (including responsive behaviours) which may impact on the placement. Where additional resources (including equipment and manpower) are required, these will be identified and agreed with the RP prior to admission;

(ii) review the existing staffing levels using an acuity and ratio based tool and will determine if the existing levels will support a new admission;

(iii) review the current training status of staff to determine whether additional support and/or training is required to support the placement.

The PIC will ensure that the care plan is prepared within 48 hours of admission. Where a resident is admitted with a current or history of responsive behaviours a record will be kept which will allow staff to identify presenting behaviours, potential triggers, the consequence of behaviours and which interactions the resident responds better to. Once this information is available, the care plan can be developed. With the residents' agreement, input will be sought from them and their family. The PIC will ensure that for all new admissions that the care plan will be reviewed and updated on a weekly basis for the first month to ensure that it adequately guides staff. It clearly identifies residents' needs and guides staff in how best to meet these needs.

The PIC will continue to monitor this "settling-in" phase and will discuss with the RP if any other resources are required and will ensure that where necessary all referrals to medical/allied health professionals are made in a timely fashion.

Regular audit of care plans will be undertaken to ensure that the care plans are comprehensive, detailed and are contemporaneous and to determine if the documented directions within the care plans are actioned in practice. The findings of these audits will be discussed at the weekly management meetings and with staff and corrective actions highlighted and assigned where appropriate.

The resuscitation status will be clearly highlighted on each resident's file and staff will be updated regularly where there is a change to the resident's status. The PIC and ADON will carry out regular audit to determine if the files are accurate and to determine if staff are knowledgeable about residents' wishes and status.

Proposed Timescale: 28/02/2018

Theme:

Effective 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 all residents availed of allied health services. Inspectors observed that a resident whose toe nail and feet required attention, had not had podiatry services since January 2017. The person in charge explained that the podiatrist was on site every three months but the resident refused the service. There was no documentary evidence that the service was offered or that alternative plans had been considered to meet the resident's needs.

9. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

Treatment offered or declined by residents will in future be fully documented in all resident records to include alternative options discussed. The resident's refusal of chiropody services was documented in the chiropodists' notes, the PIC will, in future, ask that all allied healthcare professionals or healthcare service providers document in the residents' care plans.

Proposed Timescale: 10/11/2017

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 found that the dining space was inadequate to accommodate the 13 residents in the new extension.

10. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

On 4 October 2017, during a monitoring inspection, the purpose of which was to assess the new building and vary registration conditions i.e. increase maximum number of residents to be occupied in the centre, the Inspector found that "the design and layout of the centre was suitable for its stated purpose".

The registered provider and person in charge have discussed dining and the dining

experience, and it would be their intention to have two different meal time sittings, thereby offering residents a choice of when they would like to have meals. It is proposed that residents be asked about this when their menu order is taken in the mornings.

Proposed Timescale: 07/12/2017

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:

The systems in place did not 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

11. Action Required:

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

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

The registered provider and PIC are currently reviewing the system for managing complaints, will develop new documentation and a complaints log. They will also provide complaints management training for staff.

The registered provider has nominated the PIC as the complaints manager (reference Health Act, Part 10, Regulation 34(1)(c). The PIC will ensure that all complaints are documented (regardless of the nature or whether they are resolved or not); will maintain a record of complaints; will include details of any investigations; will record outcome of the complaint and will record whether the complainant was satisfied or not.

The registered provider has nominated the operations manager as the person referred to in Regulation 34(3) to ensure that complaints are appropriately responded to and to ensure that records are maintained.

Proposed Timescale: 31/01/2018

Theme:

Person-centred care and support

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

Inspectors did not find documentary evidence that all complaints were investigated promptly.

12. Action Required:

Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.

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

The registered provider and PIC are currently reviewing the system for managing complaints, will develop new documentation and a complaints log. They will also provide complaints management training for staff.

The registered provider has nominated the PIC as the complaints manager (reference Health Act, Part 10, Regulation 34(1)(c)). The PIC will ensure that all complaints are documented (regardless of the nature or whether they are resolved or not); will maintain a record of complaints; will include details of any investigations; will record outcome of the complaint and will record whether the complainant was satisfied or not.

The registered provider has nominated the operations manager as the person referred to in Regulation 34(3) to ensure that complaints are appropriately responded to and to ensure that records are maintained.

Proposed Timescale: 31/01/2018

Outcome 16: Residents' Rights, Dignity and Consultation**Theme:**

Person-centred care and support

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

Institutional practices such as getting residents up early and serving breakfast to 18 named residents before 08:00hrs did not reflect a person-centred approach to care. While acknowledging that at least three residents liked an early breakfast, the majority of residents who spoke with inspectors did not request an early breakfast but felt it was a necessary part of the daily routine. Some residents felt it was too early to get up.

13. Action Required:

Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

The PIC has, in the form of a satisfaction survey provided residents with the opportunity to voice their preferences with regards to meal times, waking times etc. Each individual resident's choices with regards to waking times and breakfast will be accommodated and where needed work practices and duty rostering will be amended accordingly.

Proposed Timescale: 07/12/2017

Outcome 18: Suitable Staffing

Theme:

Workforce

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

Based on inspection findings inspectors concluded that the staffing levels and skill mix of staff at the time of inspection were insufficient to meet the needs of 35 residents.

14. 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:

The PIC will determine staffing levels using an acuity and ratio tool as this will support her in establishing safe and suitable staffing levels. Using both methods ensures validity and the PIC will do this monthly or more frequently if there are changes in the residents' conditions, new admissions or residents returning from hospital etc.

Proposed Timescale: 18/01/2018

Theme:

Workforce

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

Supervision of staff was inadequate.

Inspectors observed several instances where two staff were required to provide care but only one staff member was allocated to care for these residents. Unsafe practices were observed when one staff member transferred two residents from bed to chair using a hoist. The manual handling charts stated that these residents required two staff for this transfer.

15. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

Staff has been reminded of the need to adhere to procedures detailed on the manual handling charts. The PIC with the input and support of the ADON and senior carer will, through ongoing observations of care and a more formal audit programme monitor moving and handling practices to ensure that staff adhere to best practice guidelines.

The importance of this was discussed in a staff meeting on the 29 November 2017 and in the previous staff meeting before this on the 19 October 2017. Manual handling

charts are being reviewed to ensure they are accurate. Some residents, particularly those with conditions such as dementia, Parkinson's disease can have fluctuating care needs and the assistance required can vary daily. This was not reflected in the manual handling charts reviewed on the day of inspection. The PIC with the operations manager who is a trained moving and handling instructor and qualified OT will review the residents' assessments and where their abilities and needs can fluctuate will ensure that this is clearly documented on the moving and handling assessment charts.

Proposed Timescale: 31/03/2018

Theme:

Workforce

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

Training in relation to the recording of clinical practice was required based on the inspection findings.

16. Action Required:

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

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

The director of nursing has discussed the importance of good documentation with all nursing staff. All nursing staff are currently completing HSE Land training on "The Assessment of Older Person's" and this will be completed by the end of December 2017. Formal training will be included in the training schedule for the 1st quarter of 2018.

Through regular audit of care plans, the PIC will continue to monitor the quality of record keeping and through training needs analysis will determine if any further training or input is required.

Proposed Timescale: 31/03/2018