

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Holy Family Nursing Home
Centre ID:	OSV-0000349
Centre address:	Magheramore, Killimor, Ballinasloe, Galway.
Telephone number:	090 967 6044
Email address:	patrickfahey@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Holy Family Nursing Home Partnership
Provider Nominee:	Brian Fahey
Lead inspector:	Ann-Marie O'Neill
Support inspector(s):	Nan Savage
Type of inspection	Announced
Number of residents on the date of inspection:	32
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 4 day(s).

The inspection took place over the following dates and times

From:	To:
02 September 2014 10:00	02 September 2014 18:30
03 September 2014 09:10	03 September 2014 12:30
12 November 2014 09:25	12 November 2014 18:30
13 November 2014 09:40	13 November 2014 18:30

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

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

Summary of findings from this inspection

This report sets out the findings of four days of inspection carried out following an application for renewal of registration submitted by the provider.

The provider had submitted a fire compliance certificate as required in support of their application for registration renewal however; two immediate actions were issued by the Authority relating to outstanding fire compliance in September 2014. Significant works identified as required to the building in 2012, to ensure it met with building fire compliance regulations, had not been addressed.

The inspector did not continue with the registration renewal inspection in September 2014 due to the level of non compliance and identified risk. The provider was issued with an immediate action, for outstanding works to be completed within a three week period.

During the September 2014 inspection, the inspector found the Health and Safety Statement for the centre to be out of date, with the most recent report dated 2012. An immediate action was issued by the inspector for this matter to be addressed.

On the second day of inspection in September 2014, the provider made provisions for a Health and Safety officer to visit the premises and carry out a preliminary review. Subsequently, a finalised Health and Safety statement was completed and the provider addressed the issues identified by the 3 October 2014. Following completion of these immediate actions the inspector scheduled further inspection days in November 2014.

As part of the inspection the inspector met with residents and staff members, observed practices, and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

The inspector was joined by a support inspector for the first day of inspection in November 2014. On this inspection the inspector noted there had been improvements to the fire safety of the centre. For example, a no candles policy was now in operation in the centre. There were other improvements noted in the management of hazards and health and safety. The person in charge had undergone training in risk management for nursing homes and the risk register for the centre had been improved. There were more robust risk assessment measures now in place.

Overall on this inspection, the inspector found positive outcomes for the care and welfare of residents. Residents had access to allied health professional care such as physiotherapy, chiropody, dietician and speech and language therapy. Meal times observed during the inspections were unhurried and a pleasant experiences. Residents were afforded two mealtime sittings to ensure they received adequate supervision and space in the dining room.

Staff interacted with residents in a respectful and courteous way throughout the four days of inspection. Residents and family members spoken with during the course of the inspection indicated they were satisfied with the care they received in the centre. Questionnaires completed by residents and families also concurred with positive feedback.

The centre had a small and well maintained enclosed courtyard area. It also had a well designed Oratory. The centre was decorated in a pleasant, homely way throughout. Activities provided to residents were interesting and incorporated technology to provide residents with interesting and new ways of communicating with their families for example, residents had access to SKYPE. Local GAA teams visited the centre and photographs on notice boards evidenced residents were encouraged and supported to be an integral part of their local community.

There was evidence to show the provider and person in charge had made substantial efforts, since the previous September 2014 registration renewal inspection, to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

However, further improvements were required to infection control practices, premises, nutrition and privacy. The inspectors' findings are detailed in the body of the report and the areas for improvement are set out in the Action Plan at the end of the report.

Section 41(1)(c) of the Health Act 2007. 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.

Outcome 01: Statement of Purpose

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

Theme:

Governance, Leadership and Management

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

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

Findings:

At the time of the inspection, the statement of purpose was not in compliance with the regulations as changes to persons participating in management and an introduction of revised fire safety precautions within the centre were not reflected. Also the dining arrangements were not specified.

A revised statement of purpose was subsequently submitted to the Chief Inspector.

The revised statement of purpose contained most of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

It consisted of a statement of the aims, objectives and ethos of the designated centre and was a clear and accurate reflection of the facilities and service provided for residents. It also included a revised complaints procedure.

However, it did not include a description (either a narrative for or a floor plan) of the rooms in the designated centre including their size and primary function as required.

Judgment:

Non Compliant - Moderate

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There were no resource issues identified on inspection that impacted on the effective delivery of care in accordance with the statement of purpose.

There was a clearly defined management structure that identified the lines of authority and accountability. Management systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Staff meetings discussed care practice topics and how they could be improved with actions identified and staff responsible to carry them out. The provider and person in charge attended staff meetings and these occurred on a monthly basis.

There was a system in place to review and monitor the quality and safety of care and the quality of life of residents. Audits of key quality indicators occurred on a regular basis.

The person in charge and person participating in management carried out auditing of care practices such as restraint, nutrition and weights, falls, complaints and medication errors or near misses.

Although these audits collected lots of data it was not clear how the information collected influenced an improvement in care practices. For example, there had been a reduction in the level of restraint in the centre. However, it was not clear how this had come about.

An end of year audit indicated the number of falls, referrals to hospital, complaints, incidents and medication errors that had occurred in the centre in 2013. However, these numbers were not compared against those for other years. They did not indicate what improvements had been introduced as a result of the 2013 audit

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a guide in respect of a designated centre available to residents. However, the information contained in the guide was not up to date in some parts.

The guide included:

(a) a summary of the services and facilities.

However, the residents' guide did not adequately outline the dining arrangements with regard to dining facilities in the centre. There were two separate sittings for resident meals in the centre as the dining room space would not facilitate all residents using the space at one time.

(b) the terms and conditions relating to residence.

However, the residents' guide did not fully set out how money paid into residents' 'Pocket Money Account' was managed, for example. Residents' pocket money was stored in a communal fund rather than individual accounts. Therefore, residents were not fully informed of the terms and conditions relating to residence in the centre.

(c) the procedure respecting complaints.

However, the residents' guide did not contain the revised complaints procedure.

(d) the arrangements for visits.

Each resident had a written contract agreed on admission. Contracts reviewed dealt with the care and welfare of each resident in the centre.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Residents were assessed as requiring full time nursing care. There was a full-time nurse in charge of the designated centre who had a minimum of three years experience in the area of nursing of the older person within the previous 6 years. She had worked as the person in charge of the centre since 2008.

A fit person interview was conducted as part of this inspection. The person in charge demonstrated an understanding of abuse as per the centre's policy. She also highlighted

a good understanding of fire safety procedures and demonstrated a commitment to ensuring staff were competent and effective in the carrying out of evacuation procedures in the centre. She had introduced a missing person drill since the previous inspection in September 2014.

The person in charge, Sinimol Rajan, was engaged in the governance, operational management and administration of the centre on a regular and consistent basis. The person in charge held regular staff meetings to feedback positive outcomes and to direct staff care practices to enhance quality of life for residents in the centre.

Since her appointment in October 2013 she had initiated revision of governance practices for the centre. For example, the person in charge had begun carrying out monthly hygiene checks of the kitchen.

The person in charge had engaged in ongoing continuous professional development (CPD). Review of her staff file indicated extensive attendance of courses specifically related to care of the older person and management. The person in charge had attended training in management and assessing risks in residential care facilities, inspirational leadership training, October 2014. Medication management training September 2014. Prevention of falls in elderly care and residential settings, June 2014 and practical self assessment and audit skills training in June 2014.

The person in charge demonstrated a commitment to training in order to meet the needs of her role as person in charge and team leader for the centre.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Records reviewed were maintained in a complete manner in the centre. Records were kept secure, while also being easily retrievable. The sample of records reviewed indicated records in the most part were accurate and up to date.

General records relating to complaints, records of visitors, duty rosters and fire safety training, tests and maintenance of fire fighting equipment were maintained.

The centre was adequately insured against injury to residents. Other risks were insured against, including loss or damage to a resident's property. In the main staff understood the policies however, the person in charge did not demonstrate adequate knowledge of how to respond to an allegation of abuse. An allegation of abuse had been investigated, albeit thoroughly, as a complaint. This is further examined in later outcomes.

The directory of residents was maintained and contained all matters as set out in Regulation 19.

There were centre-specific policies, which reflected the centre's practice. All schedule 5 policies were in place except the required policy for staff training and development.

Policies and procedures were reviewed as required however, the policy relating to residents' personal property, personal finances and possessions did not outline the current procedures in place in the centre. This required revision to ensure it reflected the centre specific practices and procedures in place.

Some staff files however did not have a full employment history. There were some gaps in employment records. Therefore, not all staff files met the requirements of Schedule 2 of the Regulations.

Judgment:

Non Compliant - Moderate

Outcome 06: Absence of the Person in charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of the requirement to notify the Chief Inspector of any absence of the person in charge for a period 28 days or more. There were appropriate arrangements in place to manage any such absence.

There were suitable arrangements in place during the person in charge's absence and these arrangements were notified to the Authority.

The person in charge had been on leave for a period of more than 28 days earlier in the year. The correct notification had been received by the Chief Inspector. Suitable

arrangements had been implemented in her absence.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

In September 2014 the inspector found there were measures in place to safeguard residents and protect them from abuse. However, measures relating to assessment for restraint, the management of behaviours that challenge and frequency of administration of chemical restraint to manage behaviours that challenge required review.

The inspector also noted the assessment for restraint required review. It was not robust enough. It did not adequately identify the risks associated with the use of restraints such as bed rails, lap belts or chemical restraint.

Behaviour support plans for residents engaging in behaviours that challenge, did not adequately outline the triggers that caused the behaviours that challenge. Pro-active techniques, such as de-escalation, were not adequately explored, trialled or documented in residents' care plans.

Residents displaying behaviour that is challenging had a care plan in place. Chemical restraint, sedative medication given as required, was used to manage behaviours that challenge in the most part and some residents received chemical restraint regularly. Therefore, behaviour support plans were not effective in reducing the necessity for chemical restraint usage.

On the November 2014 inspection, the inspector found that the person in charge had made improvements to the assessment, intervention and review of restraint and behaviour that is challenging. There were monthly audits of restraint carried out and were shown to be up to date.

A screening tool was completed on the electronic care planning system for residents using restraint. A further restraint risk assessment tool was carried out for each resident and was maintained in a hard copy in residents' care plan files. This assessment tool was more robust in that it assessed the risk associated with the use of restraint.

There was evidence that residents' GP and next of kin/representative had signed the risk assessment having received information pertaining to the risks associated with its use. Risk reduction measures were in place for restraints residents used. There was also evidence of the use of alternatives to restraint in the centre, for example low-low beds and crash mats were in use.

The person in charge had also introduced a chemical restraint assessment tool. There was evidence to show residents' GP, member of psychiatric team and next of kin/representative had signed consent for its use. This tool provided a depression screen, behaviour screen and medication evaluation.

A resident in receipt of regular chemical restraint, for the management of behaviour that is challenging, had received review by later life psychiatry since the previous inspection. There was evidence to show that following this review, changes had been made to the resident's care plan. This had resulted in a reduced number of times the resident engaged in behaviours that challenge which in turn had an overall outcome of reduction of chemical restraint administered to them.

Overall, management of restraint and behaviour that is challenging for had improved in the centre since the inspection in September 2014.

There was a centre specific policy and associated procedures in place for the prevention, detection and response to abuse. Staff were trained in the policy and procedures. Staff spoken with knew what constituted abuse and what to do in the event of an allegation, suspicion or disclosure of abuse, including who to report any incidents to.

Any incidents, allegations and/or suspicions of abuse had been investigated and responded to but not in line with the centre's policy. The person in charge had investigated an allegation of abuse as a complaint.

There were systems in place to safeguard residents' money. Transaction and monies paid for services was maintained on a computerised system in the centre. Receipts were issued to residents for services paid for. The policy for residents' personal property, personal finances and possessions did not outline how residents' petty cash was managed, for example, a petty cash request form was no longer in use. There was also some improvement required regarding the system adopted by the provider to store residents' petty cash.

Residents that wished to maintain petty cash for sundries, not covered by their monthly fee, could pay into a petty cash account in their name on the electronic system for the centre. The actual monies were then transferred to a central Holy Family Account.

Where residents chose to or could not afford to, contribute to a petty cash fund, the central Holy Family account was used to pay for items or sundries that were not covered by the monthly fee. This system required review to ensure residents, whose money had been lodged to the Holy Family Account, was not used to pay for other residents' requirements.

Judgment:

Non Compliant - Moderate

Outcome 08: Health and Safety and Risk Management

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

Theme:

Safe care and support

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

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

Findings:

During the inspection in September 2014 the inspector found a number of significant non compliances. Two immediate actions were given on the second day of inspection. One related to fire safety and the other to health and safety.

An inspection of the premises by Galway County Council fire authority, in 2012, had identified a number of issues that required attention in order to ensure the premises met the correct standard for fire compliance. An order of construction works was set out in three phases to address issues identified by the fire authority inspection. These had been agreed between the provider and a construction engineer.

As part of the registration application process, an engineer, deemed suitably qualified, had signed off the fire compliance certificate for the building. This was submitted along with other documentation for the registration renewal application prior to September 2014.

At the time of inspection in September 2014 however, only two phases of the works had been completed. The third phase had not. This related to works required in the attic to ensure a fire, should it break out, could be contained in one zone and not spread throughout the attic to other areas.

The provider had failed to provide adequate precautions against the risk of fire, suitable building services and structures for the containment of fire by not completing all works as set out in 2012. An immediate action was given by the inspector for the remainder of works to be completed within three weeks of the action given.

The inspector also requested the provider submit an interim report, from a suitably qualified engineer, to give assurances that the works were being carried out and as per the plan of works and also a report to identify works had been completed.

Over the course of the following 20 days, the inspector received emailed assurances from engineers employed by the provider that works to address fire issues were underway and had been completed within the specified time frame.

A fire regularisation certificate from a suitably qualified engineer was submitted to the

inspector outlining they had inspected the centre on the 19 September 2014 and works were complete and in accordance with Technical Guidance Document B of the Building Regulations and to the Statutory requirements of the Fire Authority.

Other issues identified on the inspection in September 2014 related to the use of unsupervised lit candles in the Oratory of the centre. Since the September 2014 inspection, the provider had adopted a 'no candles' policy in the centre. There was signage throughout the centre to alert residents' family members of the new policy. The candles in the Oratory had been replaced to battery operated votive lights, a safer option.

There were positive fire safety management systems found on both inspections also. The inspector found on the previous inspection in September 2014 that fire drills were carried out frequently and with evidence to show they were reviewed with issues identified addressed.

Drills were comprehensive in that staff simulated mock evacuations using a dummy, for example, to make the drill as realistic as possible. This was evidence of good fire drill practice. There was evidence to show these drills had been carried out since the September 2014 inspection.

The smoking room for the centre had a fire compliant door in place, it closed fully on entering and exiting. A fire blanket and fire retardant apron was available for residents. Ventilation in the room was natural and mechanical. A fire extinguisher was situated nearby and residents had access to a call bell and phone should they need assistance. Containers with sand were used for ashtrays in the room. This ensured safe extinguishing of cigarettes.

Fire extinguishers had up to date servicing. Emergency lighting in the centre was ample and servicing documented. Training records for staff in fire safety management were up to date and indicated all staff had received training. The fire alarm panel indicated it had received an up to date service.

The inspector on the previous inspection in September 2014 also issued an immediate action in relation to health and safety auditing for the centre. The health and safety statement for the centre was out of date.

The previous statement was dated 2012. The registered provider did not have an up to date risk register identifying hazards throughout the designated centre and the measures and actions in place to control the risks identified. The inspector also identified the risk register for the centre did not adequately identify the severity of risk associated with hazards.

The provider took immediate action and a health and safety officer visited the centre on the 3 September 2014. On their preliminary inspection of the premises they found evidence of some good hazard prevention practices but, identified areas where hazards did not have adequate control. All required actions, as identified by the health and safety officer, had been completed by 3 October 2014.

There was evidence to show the risk identification system had been enhanced to now categorise the level of risk associated with hazards. The person in charge had also undergone training in risk management in nursing homes since the inspection September 2014. Adequate measures had been implemented by the provider relating to the immediate action given by the inspector in September 2014.

The centre had policies and procedures relating to health and safety. There was a comprehensive risk management policy to include items set out in regulation 26(1).

There was a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

Since the September 2014 inspection, the person in charge had updated residents' missing person's profiles and had conducted a missing person drill.

There was an ample supply of alcohol hand gels throughout the centre, these added to infection control and prevention measures. Staff had undergone hand washing training for the prevention and spread of infection. A sample of minutes from health and safety meetings indicated the prevalence of some acquired infections had increased.

While there was evidence of regular cleaning and cleaning schedules for the centre, improvement was needed to ensure regular deep clean of residents' bedrooms and high risk areas occurred to reduce the spread of infection. Open bins in residents' bedrooms were also a risk to infection control identified by an inspector during the course of the inspection and required review.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

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

Theme:

Safe care and support

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

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

Findings:

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation. Staff adhered to appropriate medication management practices.

There were appropriate procedures for the handling and disposal for unused and out of date medicines.

No resident was responsible for their own medication until an appropriate assessment was carried out confirming their capacity to do so safely. On the previous inspection in September 2014, the inspector noted there was no self administration policy or assessment in the centre.

Since then, the person in charge had researched best practice on resident self administration assessment and had drafted a policy and self administration assessment to assess residents' capacity. The inspector reviewed the assessment and found it to be comprehensive.

A system was in place for reviewing and monitoring safe medication management practices. Medication audits had been carried out. Medications were kept securely in the centre. Temperature checks were carried out daily on the medication fridge to ensure medications were stored at the correct temperature and to ensure their effectiveness.

Where residents had difficulty swallowing medications they were prescribed crushed or liquid alternatives. This was prescribed by their GP and documented on their individual medication administration charts.

Residents had a choice of pharmacist, where possible. Pharmacists were facilitated to meet their obligations to residents under relevant legislation and guidance. A pharmacist was now visiting residents in the centre every three months and evidence of this was documented in residents' files. Appropriate support was provided to residents if required, in dealings with the pharmacist(s).

Judgment:
Compliant

Outcome 10: Notification of Incidents

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

Theme:
Safe care and support

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

Findings:
A record of all incidents occurring in the designated centre was maintained.

All notifiable incidents had been notified to the Chief Inspector within three days.

A quarterly report was provided to the authority to notify the Chief Inspector of any incident which did not involve personal injury to a resident.

Judgment:

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:

These findings pertain to the inspection carried out in November 2014.

The person in charge had arranged a comprehensive assessment by appropriate health care professional(s) of the health care needs of each resident on the person's admission to the centre to identify his/her individual needs.

From the sample of care plans reviewed, residents had a personalised care plan prepared within 48 hours of their admission or thereafter as the need was identified, which detailed their assessed needs.

Residents could choose to keep their own general practitioner (GP) on admission. Health care needs were met through timely access to the recommended medical treatment.

Review of a sample of residents' files indicated that residents had access to appropriate health care including additional professional expertise to ensure their diverse care needs were met. For example, later life psychiatry, dietician, speech and language therapist (SALT), physiotherapist and occupational therapist.

From the sample of care plans reviewed, the assessment, care planning processes and clinical care was in line with evidence based practice and in accordance with professional guidelines. For example, there was evidence to show residents assessed as being at a significant risk of falls had appropriate risk reduction measures in place. Residents were assessed for their risk in developing pressure ulcers. Those identified at risk had risk reduction measures in place, such as pressure relieving mattress.

Evidenced based wound care interventions had brought about effective wound healing. Wound care plans were reviewed and updated after each dressing. Photographic evidence was maintained of the wound healing process with evidence to show wounds had healed. Residents were prescribed supplements to assist with wound healing.

Care plans were reviewed on an ongoing basis, one falls assessment and care plan was out of date however, the person in charge reviewed this care plan and changed the reflect the resident's current status. Overall, from the sample of care plans reviewed, the

care and treatment offered to residents reflected the nature and extent of their dependencies and needs.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

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

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

This outcome findings relate to the inspection carried out in November 2014.

The design and layout of the centre were in line with the Statement of Purpose. The premises met the needs of all residents and the design and layout promoted residents' dignity and wellbeing in the most part.

There was a functioning call bell system in place at each resident's bedside in both the single and twin rooms. Residents had access to an enclosed court yard in the centre of the building.

There was a separate kitchen with sufficient cooking facilities and equipment.

Residents had access to appropriate equipment which promoted their independence and comfort. The equipment was fit for purpose and there was a process for ensuring that all equipment was properly installed, used, maintained, tested, serviced and replaced. Maintenance records were documented and maintained. Equipment was stored safely and securely in the centre, for example, hoists and wheelchairs were not stored on corridors or in spaces used by residents for privacy or leisure.

There were adequate laundry and sluice facilities in the centre. There was a wash hand sink in the laundry room.

The size and layout of bedrooms was suitable to meet the needs of residents with a sufficient number of toilets and showers. There were wash hand basins in each bedroom. There were two baths in the centre. Some modification had been made to the base of one of the baths to enable a hoist to slot underneath.

The premises and grounds were well-maintained. The centre was homely with sufficient

furnishings, fixtures and fittings. The centre was suitably decorated throughout however, some fixtures for example, doors and radiator covers, required refurbishment. Some bedroom doors were scuffed and some radiator covers had small broken sections in their panel. Though there was a cleaning regimen and schedule it required enhancement. An inspector found dust had collected on the window sill and picture frame in a resident's room, for example.

Shared rooms did not provide adequate screening to ensure:

- privacy for personal care
- free movement of residents and staff
- free movement of a hoist or other assistive equipment.

When curtains were pulled fully there remained a gap. This did not allow adequate screening for residents to ensure their privacy was ensured. A sample of curtains in shared bedrooms was reviewed during the inspection.

Hand rails were on both sides of corridors and grab rails were available for residents to use in bathrooms, showers and toilet areas. Lighting in some parts of the corridors of the centre was not suitable. There were some areas that required enhanced lighting to ensure residents' independence in using corridors was as independent as possible.

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 findings of this outcome relate to the findings made during the November 2014 inspection.

There were policies and procedures for the management of complaints. The complaints process was accessible to all residents and displayed in a prominent place. However, it required some review in order to meet the regulatory requirements for example, the appeals process was not clear and the procedure incorrectly identified the Chief Inspector as part of the independent appeals process.

Residents spoken with in the centre identified the person in charge as the person they would make a complaint to. Residents spoken with raised no issue during the course of the inspection.

Complaints were recorded in the electronic care planning system, printed out and stored in a separate complaints folder for ease of retrieval. Overall details recorded for each complaint were comprehensive. They detailed action taken and satisfaction levels.

One resident's allegation of abuse had been investigated as a complaint with the outcome satisfaction of the resident ticked as 'yes'. However, it was unclear if the resident (complainant) had been satisfied with the outcome from the entries documented.

Improvements were required to the procedure. The Health Information and Quality Authority was incorrectly identified as part of the complaint/appeals process. Revision of the procedure was required to ensure it was in a more user friendly format to ensure residents and their representative clearly understood the process for making a complaint.

In the week after the inspection, a revised complaints procedure was submitted to the inspector. It was found to meet the requirements as set out in the regulations.

Judgment:

Non Compliant - Minor

Outcome 14: End of Life Care

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

This outcome was not inspected against on the previous September 2014 inspection. The findings in this outcome relate to the November 2014 inspection.

There were written operational policies and protocols in place for end-of-life care which staff were familiar with.

Care practices, plans and facilities were in place so that residents received end-of-life care in a way that met their individual needs and wishes and respected their dignity and autonomy. There was access to specialist palliative care services, when appropriate.

The centre had an Oratory which was tastefully decorated. Religious and cultural practices were facilitated. At the time of the inspection residents were predominantly of Roman Catholic faith. A commemoration Mass for residents that passed away and for residents' loved ones was held each November and a folder with Mass cards for the deceased was located in the Oratory.

Family and friends were facilitated to be with residents when they were dying. Residents at end of life were moved to a single room where possible to facilitate a dignified and private end-of-life experience.

End-of-life care plans documented discussions with residents' and their next of kin/representative in relation to their end of life wishes. There was evidence that numerous attempts to facilitate discussion on end of life had occurred with good documentation of all discussions had. This ensured the sensitive topic of end-of-life was comprehensively approached with residents. It also ensured their wishes were adequately documented as per residents and their next of kin wishes.

It was the policy in the centre to sensitively return residents' belongings. The procedure for which was set out in the end-of-life policy.

Judgment:

Compliant

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

This outcome was not inspected against on the previous September 2014 inspection. The findings in this outcome relate to the November 2014 inspection.

There was a centre specific policy for the monitoring and documentation of nutritional intake which was implemented in practice.

There was access to fresh drinking water at all times. The food provided met the dietary needs of each resident based on their nutritional assessment. Special dietary requirements of each resident were addressed.

Residents were offered appropriate assistance in a discreet and sensitive manner and enabled to eat and drink when necessary. Food was properly prepared, cooked and served.

Meals and snacks were available at times suitable to residents. The dining experience was pleasant and provided residents with adequate supervision to meet their identified needs and levels of independence. The provider had designated two mealtime sittings. The dining space could not accommodate all residents sitting for mealtimes at one sitting.

Processes were in place to ensure residents did not experience poor nutrition and hydration. Residents' nutritional risk was assessed using a recognised nutrition risk assessment tool.

Residents at risk of choking or inhaling food had received speech and language assessments for their swallow. They had also been prescribed a modified consistency diet based on this assessment. There was evidence to show this was reviewed and implemented in practice. Kitchen staff spoken with demonstrated knowledge of residents' nutritional requirement and the prescribed consistencies of their meals.

Food was available in sufficient quantities. There was a rotating menu with food choices available to residents. However, the food sampled by the inspector on both days of the November 2014 inspection, required some improvement to ensure it was wholesome and packed with flavour.

An environmental health officer report in May 2014 had highlighted issues regarding cleanliness of the kitchen in the centre and some food preparation practices. There had been a number of non compliances identified. The provider and person in charge had acted on these non compliances.

A follow up environmental health inspection had occurred 5 November 2014. This indicated there had been improvements made. The person in charge had commenced weekly checks of the kitchen to ensure adequate cleanliness was being implemented. There were some outstanding issues relating to food preparation and this was under review at the time of this inspection.

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:

This outcome was inspected against on the previous September 2014 inspection and the November 2014 inspection.

Documentation reviewed showed that residents were consulted about how the centre

was planned and run. Feedback was sought from residents and their relatives which in turn informed practice. For example, residents' committee meetings occurred every quarter. The inspector reviewed a sample of minutes from these meetings Residents were asked questions such as, 'how do you like living here?', 'how can we do things better?', 'where would you like to go on the next outing and when?', 'do you like the food'. From the feedback reviewed responses from residents were positive.

Prior to the November 2014 residents were asked to complete a Health Information and Quality Authority (HIQA) Questionnaire asking them for their feedback about the nursing home. Overall from the questionnaires completed and returned feedback was positive about the centre. Residents' next of kin and family were also asked to complete a HIQA Questionnaire for their feedback. From the questionnaires completed and returned there was overall positive feedback about the centre and how it was run.

The centre was managed in a way that maximised residents' capacity to exercise personal choice and autonomy. Residents were facilitated to exercise their civil, political and religious rights, and were enabled to make informed decisions about the management of their care through the provision of appropriate information. For example, access to news papers, news channels and information about upcoming events in the locality.

There were arrangements in place for residents to receive visitors in private. Visiting time was generally unrestricted. Visitors were requested to avoid visiting at mealtimes to ensure reduced disruption. Feedback forms from residents and relatives/friends indicated visiting and privacy during visited was supported.

The centre had an activities coordinator. Each resident had opportunities to engage in recreational activities. The activities coordinator organised excursions for individual residents based on their interests and requests. Residents often wished to visit the local graveyard, go for a pint in the local pub, go for a coffee in a cafe or attend a local site of interest.

Residents had access to Skype if they wished to use it to connect with family and friends overseas. The activities coordinator had also introduced residents to engaging in memory games for example, using a touch screen electronic hand held device. Residents' feedback was that they enjoyed using this type of technology.

The activity coordinator demonstrated to the inspector a keen passion and interest in developing a comprehensive and person centred activity package for residents in the centre. All residents did have a 'Key to Me' assessment which identified key areas of importance for residents such as birthdays and anniversaries, for example. However, there were no meaningful social care assessments in resident's care plans to ensure activities provided were in accordance with their interests and capacities.

Judgment:

Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The findings in this outcome relate to the November 2014 inspection.

Generally resident's clothing and personal property were well looked after in the centre. Resident's clothing was labelled to ensure they did not go missing. Care staff working in the centre maintained up to date logs of resident's personal belongings. An inspector reviewed the documentation and found it to be detailed with good descriptions of residents' belongings. For example, a colour photograph of a resident's substantial number of DVDs was taken to ensure an accurate record was maintained for them.

There had been a series of incidents of resident's belongings going missing. Minutes of staff meetings had indicated a review of this. Measures had been implemented by senior management in the centre, whereby spot checks were now being carried out. Staff were allocated a number of resident's and given the responsibility for ensuring their clothes were maintained properly and returned to them. The tagging system for labelling of residents clothes had also improved. All these measures had resulted in a reduction of incidents of clothes going missing.

The centre also had a system to ensure resident's valuables were stored safely if a resident or their family so wished. Storage space for clothing in resident's bedrooms was adequate.

Judgment:

Compliant

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The findings in this outcome pertain to the findings made during the November 2014 inspection.

Training was available to staff on an ongoing basis. All staff had had completed mandatory training in 2014. All nursing staff had up to date medication management training. There was evidence to indicate the person in charge and person participating in management had ongoing comprehensive continuous professional development. Staff working in the centre also had access to training on an identified needs basis.

No volunteers worked in the centre at the time of either inspection in September or November.

An inspector reviewed staff files for all recently employed staff and found An Garda Síochána vetting for all staff. There was evidence to show from a sample of staff files for longer term employees that An Garda Síochána had been obtained also.

Ongoing supervision of staff and staff appraisals were documented in staff files. There was evidence of staff signatures indicating they had read and understood policies in the centre.

The inspector reviewed the staffing rosters which indicated there was a nurse on duty at all times. Resident's dependency levels were assessed using a validated assessment tool and according to the person in charge and provider, staffing rosters were adjusted to meet resident's need requirements on a given week.

The person in charge outlined to inspectors that she ensured staff numbers were maintained based on the dependency needs of residents rather than the numbers of residents in the centre at any given time.

A planned and actual working roster for staff was maintained by the person in charge. A nurse was allocated on duty at all times in the centre. The inspector observed there to be sufficient staff on duty the two days of inspection to meet the needs of residents.

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:

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Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Holy Family Nursing Home
Centre ID:	OSV-0000349
Date of inspection:	02/09/2014
Date of response:	17/12/2014

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: Statement of Purpose

Theme:

Governance, Leadership and Management

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

The revised statement of purpose did not contain a description (either a narrative for or a floor plan) of the rooms in the designated centre including their size and primary function.

Action Required:

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing

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

the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

The Purpose and function has been updated to include the floor plan. When submitting the revised statement of purpose and function it was overlooked that the floor plan was not linked to it and this was immediately corrected by emailing the floor plan on 28/11/2014.

Proposed Timescale: 28/11/2014

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:

There was a system in place to monitor quality and safety of care and the quality of life of residents but there was no evidence of learning from the monitoring/review.

Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

There is an annual review in place since 2011 and this is reviewed continuously and updated annually and comparison made with previous years.

Our auditing files includes the following: complaints, falls, pressure sores, leg ulcers, MRSA, e-coli in urine, UTI, RTI, other infections, residents with dementia, psychotropic, sedatives, anti-depressants, challenging behaviour, mod – severe pain, chair bound, bed bound, enquiries, Adm/Discharges/Deaths, occupancy levels, residents incidents, general near miss, actual medications occurrences and weight audit.

This comprehensive list is being updated on an ongoing basis and we are presently compiling an audit chart on restraints showing how they were reduced.

Proposed Timescale: 31/01/2015

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

The residents' guide did not fully set out how money paid into residents' 'Pocket Money Account' was managed. Therefore, residents were not fully informed of the terms and conditions relating to residence in the centre.

Action Required:

Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

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

In the contract of care section 'facilities/services not included in the fees', Non-medical card items were added.

The residents guide is currently being updated to detail pocket money management procedures including making it totally clear that resident's pocket money has never been and will not be used inappropriately. All transactions will continue to be carried in accordance with regulations 20(2)(b). This system is also fully computerised.

Proposed Timescale: 31/12/2014

Theme:

Governance, Leadership and Management

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

The residents' guide did not adequately outline the dining arrangements with regard to dining facilities in the centre. There were two separate sittings for resident meals in the centre as the dining room space would not facilitate all residents using the space at one time.

Action Required:

Under Regulation 20(2)(a) you are required to: Prepare a guide in respect of the designated centre which includes a summary of the services and facilities in the centre.

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

The residents guide was updated on 12/12/2014 outlining there are two separate sittings for resident's meals.

Residents have a choice of which meal sitting to attend. Generally the residents who prefer to be up early come to the first sitting. Residents that require a level of assistance to eat and drink are also facilitated on the first sitting if they so wish. We also introduced a second sitting to facilitate family members who wish to join their loved ones.

Proposed Timescale: 12/12/2014

Theme:

Governance, Leadership and Management

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

The residents' guide did not contain the revised complaints procedure.

Action Required:

Under Regulation 20(2)(c) you are required to: Prepare a guide in respect of the designated centre which includes the procedure respecting complaints.

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

The residents guide has now been updated to include the revised complaints procedure.

Proposed Timescale: 12/12/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The policy for staff training and development was not in place.

Action Required:

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

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

The policy has been completed and was submitted to the inspector on 25/11/2014.

Proposed Timescale: 25/11/2014

Theme:

Governance, Leadership and Management

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

The policy relating to residents personal property, personal finances and possessions was not up to date as it did not reflect current practices and procedures in the centre at the time of the inspection.

Action Required:

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

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

The policy relating to residents personal property, personal finances and possessions has been reviewed and updated.

Proposed Timescale: 15/12/2014

Theme:

Governance, Leadership and Management

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

In the main staff understood the policies however, the person in charge did not demonstrate comprehensive knowledge of the abuse policy as an allegation of abuse had been investigated, albeit thoroughly, as a complaint.

Action Required:

Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

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

The person in charge has a comprehensive knowledge of the 'Abuse Policy'. HIQA have a general enquiries line to assist people with queries if clarification is sought. This service was used in this manner to gain clarification on an issue that can be ambiguous at times as we are dealing with people and sensitive issues.

Proposed Timescale: 08/12/2014

Theme:

Governance, Leadership and Management

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

Some staff files however did not have a full employment history. There were some gaps in employment records. Therefore, not all staff files met the requirements of Schedule 2 of the Regulations.

Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

All current staff files were checked and any gaps found in employment records were notified to the staff immediately for rectification.

Proposed Timescale: 31/01/2015

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 person in charge had investigated an allegation of abuse as a complaint.

Action Required:

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

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

The person in charge has a comprehensive knowledge of the 'Abuse Policy'. HIQA have a general enquiries line to assist people with queries if clarification is sought. This service was used in this manner to gain clarification on an issue that can be ambiguous at times as we are dealing with people and sensitive issues.

Proposed Timescale: 08/12/2014

Theme:

Safe care and support

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

The system for management of residents petty cash (pocket money) required review to ensure residents' money was safeguarded and not used to purchase other residents' sundries or necessities from a centralised fund.

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:

Each residents pocket money will now be held separately and not used for any other purpose. All transactions will be carried out in accordance with regulation 08(1). This system is also fully computerised.

Proposed Timescale: 31/12/2014

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

Some areas of the premises did not have even flooring, for example, the entrance to the hair dressing salon required improvement.

Action Required:

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control

accidental injury to residents, visitors or staff.

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

The one area with uneven flooring was a gap between the corridor floor covering and the hair dressing salon floor covering. An aluminium strip will be used to join the two floor coverings.

Proposed Timescale: 15/12/2014

Theme:

Safe care and support

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

Bins with no lids in residents' bedrooms were not in line with best infection control practice.

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:

Bins with lids have been purchased.

Proposed Timescale: 19/12/2014

Theme:

Safe care and support

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

Enhanced cleaning schedules and systems were necessary to ensure deep cleaning was carried out in high risk areas and residents' bedrooms for the prevention of spread of infection

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:

Presently we are cleaning all the rooms, toilets, corridors daily and deep cleaning the residents' rooms that have infections weekly. We are extending the daily cleaning to include deep cleaning of each bed and have introduced a new form to display each section of the bed has been cleaned.

Proposed Timescale: 05/12/2014

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:

Lighting in the centre required enhancement in some areas of the corridor.

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:

The lighting in some areas of the corridor has been enhanced.

Proposed Timescale: 09/12/2014

Theme:

Effective care and support

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

More attention was required to the cleanliness of the centre, for example, an inspector found dust on a resident's bedroom window sill and picture frame.

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:

Discussion with cleaning staff to be more aware of need to dust thoroughly. Also communicated to all staff that they must report any cleaning issues to the person in charge immediately so they can be rectified quickly. Person in charge to review cleaning audits. We will continue to ensure compliance with Regulation 17(2).

Proposed Timescale: 13/11/2014

Theme:

Effective care and support

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

Residents were not afforded adequate privacy as the curtains in shared rooms did not close fully.

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:

Adjustments were made to ensure that the curtain in one room now fully closes to ensure adequate privacy.

Proposed Timescale: 08/12/2014

Theme:

Effective care and support

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

Some re-decoration was necessary, for example, some bedroom doors were scuffed and small sections of radiator cover panels were broken.

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:

Scuff marks will be repaired. The damaged radiator covers will be replaced.

Proposed Timescale: 12/01/2015

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:

Satisfaction outcome for a resident was incorrectly documented as it pertained to the outcome of an allegation of abuse investigated as a complaint. The person in charge needed to ensure satisfaction ratings were a reflection of residents opinion.

Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

All complaints are acknowledged within 5 days. The complaint was investigated within 21 working days and the complainant was advised of the outcome and asked if they were happy with the outcome. In future, satisfaction outcomes for complaints will be

documented as such in accordance with regulation 34(2).

Proposed Timescale: 08/12/2014

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

While a follow up EHO inspection had indicated improvements in hygiene, some food preparation practices still required improvement.

Not all staff working in the kitchen had formal training in food preparation skills to ensure good practice was adhered to.

Action Required:

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

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

Our regular six monthly EHO report carried out on the 5th November 2014 did not indicate improvement was required with food preparation or hygiene. Indications are that the HIQA inspector used a previous report carried out on the 20th May 2014 when we were training a new chef.

The current cook has nine and a half years experience with us and has been kept refreshed and up to date on the premises by nutritionists, dieticians and speech and language therapist (SALT) who visit our centre on an ongoing basis. The cook has full up to date training with HACCP as well as all other staff associated with food. Refresher training course for cook and chef will be sourced and commenced as soon as the course time table permits.

Proposed Timescale: 30/06/2015

Theme:

Person-centred care and support

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

Improvement was necessary to ensure food served to residents was wholesome and nutritious at all times.

Action Required:

Under Regulation 18(1)(c)(ii) you are required to: Provide each resident with adequate quantities of food and drink which are wholesome and nutritious.

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

We have continuous advice and a menu analysis from Nutritionist, Dietician and Speech and Language Therapist (SALT) also our latest EHO inspection gave us a good report outcome: food preparation and wholesome nutritious value of food. We will continue to comply with Regulation 18(1)(c)(ii)

Proposed Timescale: 01/12/2014

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:

Residents had opportunities to participate in activities. However, these were not based on the outcomes of an individualised meaningful activity assessment to ensure activities provided were in accordance with residents interests and capacities

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:

We are currently implementing a comprehensive Meaningful Activities Assessment and Activity plan and the resulting outcome will be transferred to our computer system and reflected in residents activities. A Resident Activities audit will also be implemented by the Activities Co-ordinator.

Proposed Timescale: 28/02/2015