Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Sunhill Nursing Home
Centre ID:	OSV-0004450
Centre address:	Blackhall Road, Termonfeckin, Louth.
Telephone number:	041 988 5200
Email address:	Shane@sunhill.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	LSJ Care Ltd
Provider Nominee:	Shane Kelly
Lead inspector:	Sonia McCague
Support inspector(s):	Una Fitzgerald
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	69
Number of vacancies on the date of inspection:	1

About Dementia Care Thematic Inspections

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
25 April 2017 09:00	25 April 2017 18:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Non Compliant - Moderate	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Substantially Compliant

Summary of findings from this inspection

This thematic inspection focused on the care and welfare of residents who had dementia. On arrival to the centre, inspectors met with the management team of the centre who were informed of the purpose of the inspection.

Prior to the inspection, the centre completed the provider's self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016). The previous table outlines the centre's rating and the inspector's rating for each outcome.

The inspectors met with residents and staff members during the inspection. The case files of a number of residents including those with dementia within the service were

tracked. A validated observation tool was used to observe practices and interactions between staff and residents within the centre. Specific emphasis focused on residents who had dementia. Documentation such as care plans, medicine records, medical and clinical records, policies and procedures, and staff records were reviewed.

The action plan from the previous inspection were followed up and found to be addressed satisfactorily. Unsolicited information and notification received since the last inspection were also followed up.

Sunhill Nursing Home is a registered designated centre that provides care for a maximum of 70 residents. On the day of inspection there was a total of 11 residents with a formal diagnosis of dementia and a further 15 residents who have symptoms of dementia.

The inspectors observed numerous examples of good practice in areas examined which resulted in positive outcomes for residents. Staff observed were courteous and responsive to residents and visitors during the inspection. The results from the formal and informal observations were generally positive and most staff interactions with residents promoted positive connective care. In general the living environment was stimulating and also provided opportunities for rest and recreation in an atmosphere of friendliness. Residents had access to outdoor gardens that were well maintained.

There were policies and procedures available to inform safeguarding of residents from abuse. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The centre promoted a restraint free environment.

Inspectors noted some gaps in the documentation and areas for improvement were identified in management of some assessments, care plans and bedrail restraints.

Residents were consulted with and participate in the organisation of the centre. Overall, a culture of person-centred care was evident and staff worked to ensure that each resident received care in a dignified way that respected their privacy.

A range of staff training opportunities included dementia specific training courses were provided. A staff training programme was in place and any gaps had planned sessions booked to ensure all staff training is kept current and in line with best practice.

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 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self assessment tool (SAT) completed in January 2017 by the provider was rated as moderately non-compliant in this outcome with some areas for improvement highlighted. Improvements required and outlined in this outcome by the provider included a review or development of the holistic care plan, the availability of snacks and a review of bottled water provision. These matters had progressed and were to be developed further following this inspection.

Inspectors focused on the experience of residents with dementia and they tracked the journey prior to and from admission of four residents. They also reviewed specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medication management, end of life care and maintenance of records.

An admission policy last reviewed 15 August 2015 was available and was reflected in practice. Arrangements were in place to support communications between the resident and family, and or the acute hospital and the centre. The person in charge or deputy visited prospective residents in hospital or at home prior to admission. This arrangement gave the resident and or their family an opportunity to meet in person, provide information about the centre and assess or determine if the service could adequately meet the needs of the resident. However, a record of the pre-admission assessment undertaken by management staff was not available for some residents tracked by inspectors and the exclusion criteria outlined within the statement of purpose was not referenced in the admissions policy.

Residents' files held a copy of their hospital discharge letters (medical and nursing). However, the files of residents admitted under 'Fair deal' did not include the copy of the Common Summary Assessments (CSARS), which details assessments undertaken by professionals such as a geriatrician and members of the multidisciplinary team. An improvement to access and request a copy of the CSARS assessment for future

prospective residents was recommended.

Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, falls and their skin integrity. An assessment using a validated tool of the level of cognitive impairment of residents admitted with a diagnosis of dementia was recorded and subject to regular review. Assessment outcomes were linked to holistic care plans that were seen to be reviewed at intervals not exceeding four months.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to a general practitioner (GP) and allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability, dental, ophthalmology and podiatry services were facilitated on a referral basis. Some services were provided within the centre while others were available on an appointment basis within the local community.

Inspectors were informed that residents had access to psychiatry of later life services. From the cases tracked it was evident that this service had been available to some residents prior to and since their admission.

A small number of residents had superficial wounds that were being treated. One resident was reported to have a pressure ulcer that had recently developed in the centre. Inspectors tracked the ulcer and pressure area care for this resident and found that while the ulcerated area had improved, pressure ulcer grading recorded and dressings selected were not in accordance with recognised standards and treatments. The supporting care plan was not sufficiently detailed to guide practice, specify equipment in use or promote the continuity of care interventions. Another example is discussed under Outcome 2. The person in charge told inspectors that she had arranged staff training in pressure ulcer assessment and management as this need had been previously identified. Residents assessed and identified as at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Functional assessments were carried out prior to and on admission of residents. A holistic care plan was developed following admission. In the sample reviewed, information following the assessment, involvement and recommendations of allied healthcare professionals was reflected. In the main it contained sufficient information regarding the abilities and needs that guided the necessary care interventions of residents to address residents' activities of daily living needs. However, where changes in care interventions occurred frequently an alternative care plan to the holistic plan should be considered to aid updating and evaluation for care such as assessment and management of wounds or pressure ulcers.

Overall, arrangements were in place to evaluate existing care plans routinely on a four monthly basis. The care plans examined were updated or revised to reflect the residents' changing care needs. However, evidence that residents and or family, where appropriate, participated in care plan development and review arrangements at intervals not exceeding four months required improvement. Another example is referenced in

Outcome 2. A record to demonstrate their involvement was not routinely maintained.

Staff provided end of life care to residents with the support of their GP and community palliative care services. 'End of life' care plans that outlined the physical, psychological and spiritual needs of the residents within the files examined. Some included residents' expressed preferences regarding their preferred setting for delivery of care while others included that the family were to direct care at the end of life. The choice of a single bedroom was available to the majority of residents and those in shared bedrooms could be offered alternative arrangements when approaching end of life. Relatives or friends would be accommodated in facilities such as the library, oratory or visitor's room with refreshment facilities freely available.

Staff outlined how religious and cultural practices were facilitated within the centre. Residents were satisfied with the arrangements in place. There was a spacious oratory where religious services and prayer meetings were held regularly.
Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Referrals for review by a dietician and or speech and language therapist were prompted following assessment and reviews. Nutritional and fluid intake records when required were appropriately maintained. Procedures and care plans were in place in relation to nutritional care.

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

Dining arrangements were set up in three separate locations and areas, the main dining hall, a central day room and the pantry area. Some residents choose to dine in their own bedrooms, and this was facilitated. Mealtimes in these rooms were aimed at being social occasions with appropriate table settings. Staff sat with residents while providing encouragement or assistance with the lunch-time meal observed. However, based on inspectors' observations improvement was required during the dining experience to promote meaningful engagement between staff and residents. This is also discussed in Outcome 3.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk, including risk of falls. A system was in place to highlight and communicate the risk rate to all staff. A care plan specific to the identified falls risk was seen in place for residents and was updated following a fall or increase noted in risk. The use of traffic light system with colours on discreet symbols was seen on some resident's bedroom doors. Inspectors were informed that this system had been introduced to highlight and remind staff of the resident's falls risk, emergency response interventions and evacuation methods. However, some staff were unable to explain the purpose and function of the symbols and colour codes seen. Therefore improvement in the communication with staff and management systems and arrangements in this regard required some improvement.

Systems were in place in relation to transfers and discharge of residents and hospital admissions. Inspectors examined the files of residents who were transferred to hospital from the centre and found that appropriate information about their health, medicines and their needs in relation to activities of daily living were included in the medical and nurse transfer letters.

Residents had access to a pharmacist and general practitioner (GP) of their choice and the majority opted for the services of the GP that attends the centre. Arrangements that involved the pharmacist, GP and person in charge or a clinical nurse manager in medicine prescription reviews and a medicine audit system was in place.

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

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to the management of resident protection and how the centre responds and manages residents behaviours. The self assessment tool (SAT) completed by the provider was rated substantially compliant in this outcome. The actions from the last monitoring report were implemented by the management team and this was evidenced on the day.

The centre had policies in place to protect residents from suffering abuse and to respond to allegations, disclosures and suspicions of abuse. The centre now has a dedicated safeguarding officer who has attended HSE training and is certified to deliver the training. All staff had received training on identifying and responding to elder abuse. Residents were informed of this new role within the centre and this was communicated to the residents at a resident meeting as evidenced by the minutes dated the 23rd January 2017. Staff were able to explain the different categories of abuse and had knowledge of what their responsibility is should they suspect abuse. In addition staff spoken to were clear about who they would report any concerns too.

The centre has a policy on and procedures in place to support staff in working with

residents who have behavioural and psychological symptoms of dementia (BPSD). This policy was informed by evidence-based practice and implemented by staff. Staff spoken with adopted a positive, person centred approach towards the management of responsive behaviours. The inspectors reviewed a file of a resident who had BPSD. Staff spoken with by inspectors was knowledgeable on the resident's triggers and were able to voice the appropriate intervention management. However, the care plan lacked sufficient detail to guide practice. Triggers and de-escalation techniques were not clearly identified. During the inspection it was observed that staff approached this resident in a sensitive and appropriate manner.

The centre promoted a restraint free environment. Additional equipment to reduce the use of restraint such as low level beds and sensor alarms were available following an assessment and seen in use. The inspectors reviewed the care plan of two residents currently using bedrails. The care plan guided practice. Both care plans had a bedrails risk assessment and also had a falls risk assessment. There was evidence in one file that all other measures had been exhausted and this was documented. This care plan was reviewed at required intervals. However, there was no evidence that the resident or next of kin had been consulted with and consent obtained in accordance with the centres own policy. Safety checks for residents with bedrails were in place every 30 minutes. However some gaps in the documentation were identified. This was discussed with the nursing management and a review of the recording of the checks will be conducted. Inspectors were told that no residents received psychotropic medications on a PRN (a medicine only taken as the need arises) basis for management of responsive behaviours when all other interventions were tried and failed.

Systems and arrangements were in place for safeguarding residents' finances and property which met the requirements of the regulations. The accounting process was demonstrated to an inspector by staff. The procedures and processes for safeguarding residents' finances were clear and transparent. The centre was a pension agent for ten residents. Procedures were in place to facilitate residents to access their money at all times.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
The self assessment tool (SAT) completed by the provider was rated moderate non compliant in this outcome. The activity coordinator has completed Sonas training. The development of the Life Stories booklet for residents has commenced.

Within the centre there was evidence that residents were consulted with and participated in the organisation of the centre. Each resident's privacy was observed to be respected. As per the regulations facilities for occupation and recreation were available. Residents could receive visitors in private outside of the main living areas. Resident meetings were held every two months within the centre. From a review of the minutes, there was clear evidence that residents were consulted with and involved in the plan of all special occasions. There was good representation of residents with dementia in attendance at the last two meetings. The centre had carried out a resident satisfaction survey in November 2016. The results were analysed by the registered provider and changes were implemented as a direct result. For example, the menu reflects suggestions made by the residents. The centre also publishes a quarterly news letter. The April edition was seen by inspectors which evidence activity in the home to celebrate special occasions like birthdays, St Valentines day, multiple outings and the Easter festivities.

Within the centre the residents had access to independent SAGE advocacy services. Contact details of these services were strategically placed throughout the centre. Residents had access to local and national newspapers. There was a telephone in residents' rooms. Hairdressing arrangements were available to support residents personal grooming. All residents within the centre had the option to exercise their right to vote. Religious services were provided for and relatives were welcome to attend.

Residents' privacy was observed to be respected by all members of staff. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool and saw that staff engaged positively during interventions with residents with dementia. Overall the interactions were mostly positive. The inspector observed a Sonas session. Eight residents started the session. Halfway through the session a mobile resident with dementia came into the room and the staff managed this interruption without it having any negative impact on any other residents' enjoyment of the session. The inspectors also observed the dining experience for residents. Their observations were discussed with the person in charge as the observations in the main dining room was mostly task orientated throughout.

The activities programme within the centre was resident focused. The weekly activities plan offered a variety of sessions including sonas group and individual sessions, skittles, baking, arts and crafts. It was clear that the activities staff knew the residents well, including their backgrounds and personal history. The activities coordinator was working on a new initiative within the centre on a booklet called Life story. The centre had plans to recruit a second activities worker. This would enable the activity programme to carry out more one to one activities that are suitable for residents with advanced dementia and be tailored to meet their interests and capabilities.

There was active engagement between staff and residents. Within the day space and communal areas there were multiple photographs of residents and staff partaking in special events. Resident with communication difficulties were accommodated within the centre. A file of one resident with communication difficulties was reviewed and the care plan guided practice. The centre had tried a variety of techniques and in consultation with the resident had found that the alphabet board was most suited to this resident's

needs. The communication care plan within the resident's file guided practice.

The centre had a laundry service and there was suitable arrangements in place to ensure that residents own clothes were laundered and returned to them. Each resident had a wardrobe space and a locked drawer in their private bedroom.

There was a good relationship between staff and residents in the centre, and visitors were greeted in a welcoming manner. There were many visitors in the centre on the day of this inspection and there were a number of areas where residents could meet with visitors in private. Family members told inspectors they were welcomed and had an opportunity to speak with staff when visiting. A record of visitors to the designated centre was available and maintained. Overall, a culture of person-centred care was evident and staff worked to ensure that each resident received care in a dignified way that respected their privacy.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
The were policies and procedures in place for the management of complaints.
The complaints process was displayed in a prominent place in the reception area. The centre had a log of all complaints and there was no written complaints received in 2017. Three separate pieces of unsolicited information had been received by the authority since the last inspection. The inspectors were satisfied that all complaints brought to their attention of the provider were dealt with according to their complaints policy and are in line with the requirements as set out in the regulations.

Concerns received were investigated promptly, a record was kept and the outcome was documented. Residents spoken with told inspectors that they would not hesitate to make a complaint if they had one. Relatives said they were satisfied with the care given and were aware of who they could complain to if they needed to. Staff spoken to were also aware of the policy on complaint management.

An advocacy service was available if required by any resident to support them.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors reviewed actual and planned rosters for staff, and found that staffing levels and skill mix were sufficient to meet the needs of residents. Ongoing review of resident dependency and staffing levels were monitored to inform staffing levels and skill mix. Staff spoken to confirmed that they had sufficient time to carry out their duties and responsibilities and clinical nurse managers explained the systems in place to supervise staff. Staff spoken with also felt supported by the person in charge and the provider.

Staff were seen to be supportive of residents and responsive to their needs. Inspectors spoke with a number of residents' relatives who were complimentary of the staff and of the care that was received.

Evidence of current professional registration for all registered nurses was available. A staff training programme was maintained. The matrix identified which staff had attended training, which was due to attend and the dates of courses planned. Training records showed that extensive training had been undertaken and staff spoken with confirmed this. This included training on Safeguarding and safety, dementia training, the management of behaviours that challenge, fire training, manual handling and cardio pulmonary resuscitation. Although some gaps were identified with the management of residents with behaviours that challenge the centre had confirmed dates of when staff would have completed same by June 2017.

Recruitment and induction procedures were in place. All documents as required by Schedule 2 of the regulations for staff were maintained. While not all documentation was in place prior to the commencement date, it was present on the day of inspection.

The inspectors were informed there were no people involved on a voluntary basis within the centre at this time.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

No actions were required from the previous inspection.

Findings:
The self assessment tool (SAT) completed in January 2017 was rated as a moderate non-compliance in this outcome.

The action plan response included improvements to be made in relation to colour schemes, directional and visible signage, and photographs on or at resident's bedroom doors. It also included the improvement and accessibility of existing outdoor spaces. These improvements had commenced and were to be rolled out throughout 2017 as part of the refurbishment plan.

Sunhill Nursing Home is purpose built registered to accommodate 70 residents at ground floor level. It had 52 single and nine twin bedrooms. Plans to extend the centre had been initiated to increase occupancy of the centre by 22.

The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre.

The centre was found to be reasonably well maintained, warm, comfortably and visually clean in most parts. Some areas in the pantry were unclean and cupboard doors were in need of repair. In addition, some improvement was required in relation to the paint and decor in parts which was worn and in need of repair.

The communal areas such as the dining room and the day room had a variety of comfortable furnishings and were domestic in nature.

Heat, lighting and ventilation were adequate and the temperature of the building met requirements in bedrooms and communal areas where residents sat during the day. The lack of movement between rooms by some residents was highlighted to the management team for improvement. Inspectors observed that some residents remained in the same day room for all activities including dining.

Sitting rooms, lounges and dining rooms were spacious and decorated to a reasonable standard with colourfully co-ordinated soft furnishings, flooring and appropriate fittings in most. The provision of side tables would be beneficial to residents in some communal sitting rooms to support them with magazines, papers, tea cups, snacks and drinks was recommended.

Corridors and door entrances used by residents were wide and spacious to facilitate movement and aids used and required by residents. Bedrooms were spacious to accommodate personal equipment and devices required by existing residents. Handrails were available in all circulation areas throughout the building, and grab rails were present in all toilets and bathrooms. Furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Supportive equipment such as call bell facilities, remote control devices, hoists and mobility aids were seen in use by residents that promoted their independence.

Inspectors found that the privacy and dignity of residents was promoted in each

bedroom and by its layout. Many rooms were personalised with photos, memorabilia and artefacts. Some rooms had clocks or calendars to orientate residents to time and date. However, some aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia. As identified in the SAT, the provision of signage and use of colour schemes required enhancement throughout the building. For example, the use of contrasting colours in corridors and on assistive equipment in communal toilets was needed. While some contrasting colours were noted in some bedrooms and facilities, additional signage, picture aids and cues were required to support residents to navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

Residents had access to safe and enclosed outdoor areas with seating, paths and flower beds. One outdoor space had been developed since the last inspection and others were to be developed further. An outdoor enclosed smoking area was also available to residents off the main corridor.

Catering and laundry facilities were available in the centre. Ample car parking facilities was also available.

Judgment:
Substantially 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:

Sonia McCague
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 report[1]

Centre name:	Sunhill Nursing Home
Centre ID:	OSV-0004450
Date of inspection:	25/04/2017
Date of response:	22/05/2017

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The admission exclusion criteria outlined within the statement of purpose was not referenced in the admissions policy.

1. 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

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

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:
Admissions policy to be updated to include the exclusion criteria.

Proposed Timescale: 06/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff were unable to explain the purpose and function of the symbols and colour codes seen on residents bedroom doors so as to meet their assessed needs.

2. 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 colour coded system has been reviewed with staff since the inspection and we continue to do this at handovers and Fire drills etc.

Proposed Timescale:
1st May 2017 & ongoing

Proposed Timescale: 22/05/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The care plan for a resident with a pressure ulcer was not sufficiently detailed to guide practice, specify equipment in use or promote the continuity of care interventions.

Evidence that residents and or family, where appropriate, participated in care plan development and review arrangements at intervals not exceeding four months required improvement.

3. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

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

Although we had developed the Holistic Care plan for all residents, a separate care plan for Wound Management has now been developed that is more descriptive to help guide practice.

Holistic Care plans to be reviewed formally with all families/Residents

Proposed Timescale: 01/07/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Pressure ulcer grading recorded and dressings selected were not in accordance with recognised standards and treatment.

4. 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:
All Nursing staff have completed Wound management training again as this was something that had been identified as a need prior to the inspection with the TVN Nurse.

Proposed Timescale:
4th May 2017 - complete

Proposed Timescale: 22/05/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A record of the pre-admission assessment undertaken by management staff was not available for some residents tracked by inspectors.

The files of residents admitted under 'Fair deal' did not include the copy of the Common Summary Assessments (CSARS).

5. 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:
A copy of CSAR forms have been requested for residents. All admission assessments are now uploaded immediately on to the Residents File.

Proposed Timescale: 10/06/2017

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plan specific to residents behaviours that challenge require a review to ensure they guide practice. Triggers and de-escalation techniques were not clearly identified.

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

Please state the actions you have taken or are planning to take:
Although we had developed the Holistic Care plan for all residents, a separate care plan for Behaviours that Challenge which is more detailed will be developed to include triggers were possible and de-escalation techniques.

Proposed Timescale: 02/06/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that the resident or next of kin had been consulted with and consent obtained as per the centres own policy. Safety checks for residents with bedrails were in place every 30 minutes. However some gaps in the documentation were identified.

7. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
All bedrails are used as enablers in the centre as per the resident's wishes. Consent forms to be signed for this. Weekly Audits are carried out to ensure that the release of bedrails in the morning is documented when the resident gets up.

Proposed Timescale: 02/06/2017

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Based on inspectors' observations improvement was required during the dining experience to promote meaningful engagement.

The inspectors observed the dining experience for residents in the main dining room as mostly task orientated throughout.

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

Please state the actions you have taken or are planning to take:
A further QUIS study to be carried out to involve staff themselves. We had identified prior to the inspection that the dining experience required a lot of improvement. Kitchen and management team visited a Nursing Home in Waterford. There will now be two chefs working in the Kitchen with one chef each day to serve the residents meals table by table. A quiz to be developed to engage residents while waiting for their meals.

Proposed Timescale: 31/07/2017

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff members receive supervision but this was not supported by written policies. Records of supervision are not consistently maintained.

9. 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:
Appraisal policy to be developed and this is also to be included in the Staff Handbook.

Proposed Timescale: 30/06/2017

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The lack of movement between rooms by some residents was highlighted to the management team for improvement. Inspectors observed that some residents remained in the same day room for all activities including dining.

Some areas in the pantry were unclean and cupboard doors were in need of repair.

Improvement was required in relation to the paint and decor in parts which was worn and in need of repair.

The provision of signage and use of colour schemes required enhancement throughout the building.

Additional signage, picture aids and cues were required to support residents to navigate the centre and locate their bedrooms, indoor and outdoor communal areas and bathroom facilities.

The provision of side tables would be beneficial to residents in some communal sitting rooms to support them with magazines, papers, tea cups, snacks and drinks was recommended to promote independence.

10. 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:
Extra signage to be installed as per the self-assessment.
Extra tables for the sitting rooms to be purchased.
The corridors to be repainted with different contrasting colours.
Pantry Kitchen deep cleaned and Maintenance carried out on the day following the inspection. Dishwasher to be installed in the pantry area.
The dining experience and were the residents have their meals to be reviewed for residents in the country Kitchen area.

Proposed Timescale: 01/09/2017