

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Prague House
<b>Centre ID:</b>	OSV-0005447
<b>Centre address:</b>	Chapel Street, Freshford, Kilkenny.
<b>Telephone number:</b>	056 883 2281
<b>Email address:</b>	praguehousefreshford@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Prague House Care Company Limited By Guarantee
<b>Provider Nominee:</b>	Paul Murphy
<b>Lead inspector:</b>	Ide Cronin
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	19
<b>Number of vacancies on the date of inspection:</b>	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.

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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

From: 15 August 2017 09:10 To: 15 August 2017 15:50

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

**Summary of findings from this inspection**

This report sets out the findings of an unannounced, one day inspection, the purpose of which was to monitor ongoing compliance with the regulations. Prague House is registered to accommodate 22 residents who have been assessed being low dependency and hence require minimal support with the activities of daily living. If dependency needs of residents change alternative accommodation is sought for the resident as outlined in the statement of purpose.

The needs of the residents has determined that full-time nursing care is not required, therefore, two nurses are on duty approximately 15 hours per week, which is split over three days per week. The inspector also followed up on the progress of the action plans generated from the previous inspection in August 2016. The person in charge had also changed since the last inspection and a fit person interview had been carried out in the Health Information and Quality Authority (HIQA) head office prior to this inspection.

The designated centre was operated on a voluntary basis with an established system of governance in place via a board of management. Care staff are on duty on both day and night shifts. Day care services are also provided to older people on a weekly basis. People who attend the day service are offered a program of social activities and they join other residents for meals.

The inspector spoke with residents and staff during the inspection. Overall, the inspector noted that a warm atmosphere prevailed in the centre. Residents told the inspector how happy they were and stated that they could come and go as they pleased. Staff exhibited an in-depth knowledge of the residents and their backgrounds and were observed caring for residents in a respectful manner while maintaining residents' privacy and dignity. There was constant activity with numerous residents and visitors coming and going as observed by the inspector

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland (2016).

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

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The designated centre was operated on a voluntary basis with an established system of governance in place via a board of management. The person in charge said that the governance structure was supportive of both staff and the person in charge.

The board of directors oversee the organisational, financial and management of the centre. Currently the board meet on a weekly basis as the management structure is relatively new in relation to the change of person in charge.

Minutes of meetings were available and standing items were on the agenda such as day care services and finance. There were a number of sub-committees established which various board members sit on relevant to their area of expertise such as building projects, finance and health and safety. Funding for the service is granted under a service level agreement with the Health Service Executive (HSE) under section 39 of the Health Act, 2004, voluntary fundraising, and residents' own contributions.

A quality management system was in place and a schedule had been devised to ensure that audits were completed. Areas subject to audit included matters such as medicines management, residents' rights, privacy and dignity, safeguarding and care planning. There was evidence of learning from audits and improvements being implemented such as care plans being developed for the delivery of personal care.

However, the inspector found that the audit process required some further development to ensure it identified all areas requiring improvement such as medicines management and care planning. The audits did not always include when the action was implemented or checked to determine effectiveness which would ensure positive outcomes for residents.

Consultation with residents/relatives in relation to the existing systems of monitoring quality of care was available. A residents' committee was in operation. An annual review

of the quality and safety of care delivered to residents had taken place for 2016 which informed the service plan for 2017.

**Judgment:**

Substantially Compliant

***Outcome 04: Suitable Person in Charge***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The person in charge had changed since the time of the last inspection. The current person in charge has worked in care of the older persons services for many years and is full-time in this role. There was a clearly defined management structure in place to support the person in charge.

The inspector spoke with staff and residents, and found that there was a clear reporting mechanism and management structure in place. The inspector was satisfied that the management arrangements in place ensured that the assessed needs of residents were being met and monitored. The person in charge had deputising and on call arrangements in place to ensure adequate management of the centre during her absence.

**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:**

Only the component of policies and procedures were considered as part of this outcome. The inspector observed that the medicines management policy consistently referenced nursing staff administering medicines. However, for the most part in this centre, care staff administer medicines to residents.

Transcribing practices required improvement. The centre's policy in relation to transcribing and guidance issued by An Bord Altranais agus Cnáimhseachais was not consistently implemented in practice. The inspector observed that transcribed orders were not signed and dated by the transcribing nurse nor was it co-signed by the prescribing doctor as outlined in the centre's policy.

The inspector observed that the temperature of the refrigerator was not monitored daily.

**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 and person in charge demonstrated they were aware of the responsibility to notify the Chief Inspector 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 her absence.

The assistant manager has worked in the centre for 22 years. The inspector engaged with her during inspection and found that she was knowledgeable regarding residents' needs. She told the inspector that that the board would always be available to her when the person in charge was on leave.

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

**Findings:**  
There was a policy on and procedures in place for, the prevention and detection and response to abuse dated July 2016. The person in charge stated that all staff had received training in safeguarding vulnerable adults and staff who spoke with the inspector confirmed they had received training. Staff who spoke with the inspector confirmed that they knew what to do in the event of an allegation or suspicion of abuse.

The person in charge informed the inspector that there were no residents who displayed responsive behaviours. Training had been provided for staff in this area. There was good access to mental health services if required. A policy, which gave guidance to staff on how to manage responsive behaviours, was also available. There was a communication policy also available.

There was a policy on restraint but the person in charge said the practice in the centre was one of a restraint free environment and restraint would only be used in very emergency situations. The inspector saw that restraint was not common place in the centre and none were in use on this inspection.

A policy was in place for the management of residents' personal property, finances and possessions. Policy was in keeping with the independent resident profile and residents retained responsibility for the management of their own finances.

The inspector reviewed the measures that were in place to safeguard residents' money and found that the systems in place were not sufficiently robust. Most residents managed their own finances and the inspector noted that the staff offered whatever practical support was necessary including taking residents to the post office if this was needed. The inspector saw that money for one resident was stored in a safe and transactions were not co-signed and witnessed by two staff members or the resident which did not safeguard residents' money or staff.

**Judgment:**  
Substantially Compliant

***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:**

The inspector found there were management systems in place to ensure that the health and safety of residents, visitors and staff promoted and protected. The centre was secure and there was a visitors log at the front door.

A risk management policy dated July 2016 was in place that included the areas described in regulation 26(1). There was information on general hazard identification that outlined general and clinical risk areas. Risk management was supported by individual risk assessments for residents linked to their assessed needs. There was a risk register in place.

Fire precautions were prominently displayed throughout the centre. Service records showed that the emergency lighting, fire alarm system and fire fighting equipment were serviced and fully maintained. The inspectors noted that the means of escape and exits, which had daily checks, were unobstructed. All staff had attended training and those spoken with were knowledgeable of the procedure to follow in the event of a fire. Regular fire drills had taken place the last one was held on 18 July 2017 and evacuation times were recorded. The inspector saw that the fire alarm was tested and serviced on a regular basis.

There was an emergency plan that outlined the procedures to be followed in the event of emergencies such as fire, bad weather, loss of water and loss of power. There was an infection control policy in place. There were procedures in place for the prevention and control of infection. Hand gels, disposable gloves and aprons were appropriately located within the centre. The centre was visually clean and additional housekeeping hours has been designated to deep cleaning since the previous inspection.

There was a system for recording accidents and incidents in the format of quarterly reports. There was evidence that incidents were being reviewed and appropriate actions taken to remedy identified defects. The inspector saw that each resident's moving and handling needs were identified and outlined in an assessment. However, manual handling training was not up-to-date for all staff. This is actioned under Outcome 18: Staffing.

**Judgment:**

Compliant

***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:**

A centre-specific policy on medication management was in place which covered the required areas of prescribing, administration, storage and disposal. The centre engaged the services of the local community pharmacist. Residents were appropriately advised by the pharmacist in relation to their medications. Where residents were self-administering an appropriate tool for assessment and review was available.

Medicines were appropriately stored and the management of controlled drugs was safe and in accordance with current guidelines and legislation. The inspector checked the stock balance and noted that all were correct and appropriately recorded. Adequate refrigerated storage was in use for medicines that required temperature control. However, the temperature of the refrigerator was not monitored daily. This is actioned under Outcome 5. The inspector noted that the medicine trolleys were secured and the medicine keys were kept by a staff member at all times.

The inspector found that some practices in relation to administration recording and review of medicines did not meet with professional or regulatory requirements. Some residents were not sufficiently protected by medication management practices and procedures found in the sample of residents' records inspected.

**Issues identified included:**

There were gaps identified in some medicine administration records reviewed, therefore it was impossible to ascertain if the medicines had been given to the resident or not.

The inspector observed that the date of opening was not recorded for a medicine that had a reduced expiry date when opened. Therefore, staff could not identify when the medicine would expire.

The administration sheets reviewed were legible and distinguished between p.r.n (a medicine given as the need arises), regular and short term medicines. However, all medicines were not prescribed individually by the prescriber in all of the medicine charts reviewed by the inspector.

Transcribing practices required improvement. The centre's policy in relation to transcribing and guidance issued by An Bord Altranais agus Cnáimhseachais was not consistently implemented in practice. The inspector observed that transcribed orders were not signed and dated by the transcribing nurse nor was it co-signed by the prescribing doctor as outlined in the centre's policy. This is actioned under Outcome :5.

**Judgment:**

Non Compliant - Moderate

***Outcome 11: Health and Social Care Needs***

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

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

All of the residents living in the centre had been assessed as low dependency and did not require full-time nursing care. From the sample of four residents' files reviewed the inspector saw that each resident's wellbeing and welfare was maintained by a good standard of evidence based nursing care and appropriate medical and allied health care.

There was evidence that timely access to health care services was facilitated for all residents. A number of general practitioners (GPs) were attending to the needs of the residents and an "out of hours" GP service was available if required. Residents were also encouraged to visit the GP if needed. Records confirmed that residents were assisted to achieve and maintain the best possible health through medicine reviews, and annual administration of the influenza vaccine.

Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had ongoing access to allied healthcare professionals including dietetics, speech and language therapy, diabetic clinic and physiotherapy. The inspector also saw that residents had easy access to other community care based services such as dentists and opticians.

Residents, where possible, were encouraged to keep as independent as possible and inspectors observed residents moving freely around the centre and outside. Some residents told the inspector that they enjoyed a walk down town or some went across the road to the local church as they wished. One resident told the inspector that he liked to go out to the local pub during the week. Residents said they were satisfied with the healthcare services provided.

Residents' social care needs were met and residents had opportunities to participate in some activities, appropriate to their interests and preferences. The inspector saw that a

social care plan was developed for each resident on admission based on the resident's hobbies and interests.

The inspector saw that a "Key to Me" had been developed for residents. The inspector saw that some residents had their own cars and came and went as they pleased. However, there was inconsistent evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated. As the centre provided care for residents of low dependency there was a protocol in place for the management of increasing dependency need and assessments undertaken for resident's requirement to move to nursing care.

Healthcare staff and an activity volunteer attended the centre three days per week and directed activities which included exercise, cards, bingo and reminiscence. Residents were consulted with and participated in the organisation of the centre. They were supported to make choices, to be independent and to develop and sustain friendships. Residents in the main led purposeful lives, they decided how to spend their day and there were opportunities to participate in activities. There was an active residents' committee and the last meeting had taken place on 29 July 2017. However, the inspector saw that an issue raised by residents on the previous two meetings which was in relation to the provision of a call bell in the day room still had not been addressed. This is actioned under Outcome 12: Premises.

**Judgment:**

Substantially Compliant

***Outcome 12: Safe and Suitable Premises***

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

**Theme:**

Effective care and support

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

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

**Findings:**

The centre opened in 1974 as a voluntary service for the purpose of providing supported care for members of the local community. The centre was located in the town centre with good access to the amenities available such as the church, town hall, local stores and services. In general, the design and layout of the centre were suitable to meet the individual and collective needs of the residents, in keeping with the centre's statement of purpose. A previous action from the last inspection in August 2016 to provide sluicing

facilities had not been progressed in line with the provider's action plan.

The centre provided accommodation for a total of 22 residents in 20 single rooms and one twin room. Two of these rooms had en-suite facilities, while the remainder contained hand wash basins. A number of toilets, shower rooms and an assisted bathroom were located throughout the building. A functioning call bell system was in place in the centre. However, as outlined in Outcome: 11 there was no call bell in the day room.

While the majority of bedrooms contained the furniture and storage facilities as required by the regulations, the layout of the twin bedroom did not ensure that the privacy of both residents was maintained at all times. The person in charge informed the inspector that there were proposed plans in place to divide the bedroom into two single rooms with built in wardrobe space and wash-hand basin. There were also plans to redevelop the garden area creating a walk way to the rear of the garden which would include flower beds, vegetable garden and a seating area.

There were a number of communal areas for residents including a large sitting room which had been redecorated since the previous inspection and was bright and spacious with good use of artificial lighting. A lift was available to residents to support movement between communal rooms on the ground floor and bedrooms on the first floor. Laundry facilities were provided on-site.

**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):**

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

**Findings:**

The centre had a complaints management system in place, which included a complaints policy and procedure that met the requirements of the regulations. A summary of the complaints process was displayed prominently at the reception of the centre. There was a complaints log that was used to record any complaints.

The inspector read a sample of complaints that had been received and found that issues raised had been appropriately responded to by the person in charge. Details recorded included the nature of any complaint and actions taken and the outcome of the complaint including the satisfaction level of the complainant with the investigation was

recorded as required by legislation.
<b>Judgment:</b> Compliant

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

**Findings:**  
Only the component of the previous inspection was considered as part of this inspection. On the previous inspection it was found that in the care plans reviewed there was limited evidence that the end-of-life needs and wishes of residents were discussed with them and/or their next of kin as appropriate and documented in a care plan. The care plans reviewed by an inspector did not address the resident's physical, emotional, social and spiritual needs. They did not reflect each resident's wishes and preferred pathway as part of their end of life care. There were inconsistencies in relation to the resident's involvement in the decision making process relating to end of life care.

This action has not progressed any further since the previous inspection.

**Judgment:**  
Non Compliant - Moderate

**Outcome 18: Suitable Staffing**  
*There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**  
Workforce

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

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

**Findings:**

The inspector was satisfied that there were appropriate levels and skill mix of staff to meet the assessed needs of the residents. An actual and planned staff rota was made available to the inspector on the day of the inspection. Due to the low dependency of residents in the centre, a nurse was not required to be on duty at all times. However, the person in charge and registered provider ensured that 15 hours of nursing care was provided every week.

There was a policy in place for the recruitment, selection and vetting of staff. The inspector reviewed a sample of staff files, which were found to contain all of the necessary information required by Schedule 2 of the regulations. Both nursing staff were found to have up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland). The person in charge said that all staff and seven volunteers were Garda vetted. The inspector also reviewed a sample of volunteer files and found that all were Garda vetted.

A training record for staff was maintained in the centre, which was made available to the inspector on the day of the inspection. The record indicated that while all staff were trained in fire safety and the prevention, detection and management of abuse not all staff had received up-to-date training in moving and handling practices. Staff demonstrated to the inspector their knowledge in a number of areas for example fire safety and adult protection. Staff who spoke with the inspector confirmed that they were supported to carry out their work by the person in charge.

There was an induction programme for new staff, which included training and supervision. Staff had received appraisals in 2016, the person in charge told the inspector that she planned to complete the appraisals before the year end. The inspector saw that a staff meeting had been held prior to the inspection.

**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:***

Ide Cronin  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

# Health Information and Quality Authority Regulation Directorate

## Action Plan



### Provider's response to inspection report<sup>1</sup>

Centre name:	Prague House
Centre ID:	OSV-0005447
Date of inspection:	15/08/2017
Date of response:	04/09/2017

### Requirements

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

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

### Outcome 02: Governance and Management

**Theme:**  
Governance, Leadership and Management

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

The inspector found that the audit process required some further development to ensure it identified all areas requiring improvement such as medicines management and care planning. The audits did not always include when the action was implemented or checked to determine effectiveness which would ensure positive outcomes for residents.

**1. Action Required:**

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

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

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

Staff Nurses to undertake more audits including medicines management, and all audits will now include a date action implemented and reviewed.

**Proposed Timescale:** 30/09/2017

**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:**

Practices as outlined in the centre's policy and procedures were not adapted such as transcribed medicine orders were not signed and dated by the transcribing nurse nor was it co-signed by the prescribing doctor as outlined in the centre's policy.

The inspector observed that the temperature of the refrigerator was not monitored daily.

**2. Action Required:**

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

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

Medication fridge temperatures now being logged daily 15 August 2017

New MAR's being developed to include signature of transcriber.

Where a GP's signature is not on the MAR's a copy of the script will be held on site.

The policy on medicines management will be updated to reflect this practice.

**Proposed Timescale:** 30/09/2017

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

The inspector saw that money for one resident was stored in a safe and transactions were not co-signed and witnessed by two staff members or the resident which did not safeguard residents' money or staff.

**3. 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:**

Log now in place recording all transactions and being signed by two members of staff and the resident.

**Proposed Timescale:** 15/08/2017

**Outcome 09: Medication Management****Theme:**

Safe care and support

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

There were gaps identified in some medicine administration records reviewed, therefore it was impossible to ascertain if the medicines had been given to the resident or not.

The inspector observed that the date of opening was not recorded for a medicine that had a reduced expiry date when opened. Therefore, staff could not identify when the medicine would expire.

**4. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Medication management, administration and recording training is due to be carried out with staff on Thursday 07 September 2017.

A medication round tabard has been purchased to avoid disruptions to staff on medication round.

Date of opening is now present on medicines with reduced expiry date when opening.

**Proposed Timescale:** 07/09/2017

**Theme:**

Safe care and support

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

Ensure that all medicines are prescribed individually by the prescriber.

**5. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

If a GP is issuing a new script off site a copy of that script will be maintained on site until we can obtain the GP's signature on MAR's as soon as possible. As all GP's are not local and do not always attend site this will avoid a gap in treatment.

**Proposed Timescale:** 30/09/2017

**Outcome 11: Health and Social Care Needs**

**Theme:**

Effective care and support

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

There was inconsistent evidence of residents or their representative's involvement in the discussion, understanding and agreement to their care plan when reviewed or updated.

**6. Action Required:**

Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

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

Care plans have now been discussed with residents and the residents wishes reflected in the care plans. Residents have now signed same.

**Proposed Timescale:** 01/09/2017

**Outcome 12: Safe and Suitable Premises**

**Theme:**

Effective care and support

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

There were no sluicing facilities in the centre. The layout of one of the bedrooms did not ensure the privacy of residents was maintained at all times.

There was no call bell in the day room.

**7. 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:**

Call bell is due for completion 08 September 2017.

The addition of a sluice is due for commencement on 30 September 2017.

A mobile privacy screen is available in the double bedroom to maintain resident's privacy. However, plans are in place to divide the bedroom into two single rooms. This is due to be completed by August 2018.

**Proposed Timescale:** 31/08/2018

**Outcome 14: End of Life Care****Theme:**

Person-centred care and support

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

The inspector observed in a sample of care plans reviewed that there was no evidence that the end-of-life needs and wishes of residents were discussed with them and/or their next of kin as appropriate and documented in a care plan.

**8. Action Required:**

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

The staff nurse will discuss end-of-life care preferences and wishes with residents and develop care plans on same in conjunction with each resident.

**Proposed Timescale:** 30/09/2017

**Outcome 18: Suitable Staffing****Theme:**

Workforce

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

Ensure that all staff have up-to-date training in moving and handling practices.

**9. Action Required:**

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

appropriate training.

**Please state the actions you have taken or are planning to take:**  
Training due is now being planned.

**Proposed Timescale:** 30/10/2017