

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Corrandulla Nursing Home
<b>Centre ID:</b>	OSV-0000332
<b>Centre address:</b>	Corandulla, Galway.
<b>Telephone number:</b>	091 79 1540
<b>Email address:</b>	corrandullanursinghome@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Hayden Healthcare Limited
<b>Provider Nominee:</b>	Michael Hayden
<b>Lead inspector:</b>	Ann-Marie O'Neill
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	35
<b>Number of vacancies on the date of inspection:</b>	2

## **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 3 day(s).

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

From:	To:
10 December 2014 11:20	10 December 2014 18:30
11 December 2014 10:10	11 December 2014 17:00
05 January 2015 10:30	05 January 2015 16:10

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**

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

Overall, the inspector was satisfied that residents were receiving a quality service. There was evidence of a substantial level of compliance, in a range of areas, 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.

The centre was managed by a suitably qualified and experienced nurse who was accountable and responsible for providing a high standard of care to residents. The health needs of residents were met to a good standard. Residents had access to general practitioner (GP) services, to a range of other health services and evidence-based nursing care was provided.

The provider frequently visited the centre and residents spoken with indicated he was a person they would speak to if they were worried or had a complaint or issue. The premises met the needs of all residents and the design and layout promoted residents' dignity, independence and wellbeing in the most part. The centre had originally been a Monastery. The original Chapel attached to the centre was still in use and had been maintained with authenticity.

End-of-Life care plans were detailed and gave a sensitive, comprehensive outline of residents expressed end-of-life wishes. Where residents were unable to express their wishes, end-of-life plans provided detail of residents likes and dislikes and preferences as were known prior to a deterioration in the residents' health.

Residents were overheard to compliment food served during mealtimes. Care and supervision during mealtimes was dignified and sensitive to residents needs. However, there were not enough staff available during mealtimes to ensure this good practice was consistently implemented throughout the mealtime experience.

There was non-compliance found in Outcome 2, related to audits and review of key quality indicators. Outcome 5, staff files did not contain all matters set out in Schedule 2 of the Regulations. Non compliance was also found in relation to the maintenance of individualised logs for residents' monies and Outcome 8, where improvement was required to the fire safety policy to ensure it reflected the fire safety and management procedures that were in action in the centre.

Areas of compliance and non compliance are discussed further in the report and included in the Action Plan at the end of this 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):**

No actions were required from the previous inspection.

**Findings:**

The statement of purpose contained all 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 reflection of the facilities and service provided for residents.

**Judgment:**

Compliant

***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 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.

The provider attended the centre regularly and was well known to residents. Residents informed the inspector they knew the provider by name and identified him as a person

they would speak to if they had a complaint or concern. The provider had a good rapport with residents and looked for verbal feedback from residents on the quality of care they received when he visited the centre, which he did regularly.

There were some resource issues identified on this inspection that could impact on the effective delivery of care in accordance with the statement of purpose. There were staffing shortages at the time of inspection. The provider and person in charge were engaging in a recruitment process to resolve the issue.

Two staff had been recruited with one due to start working in the centre at the end of January 2015. The second staff member was due to start work in April 2015. In the meantime, the person participating in management (PPIM) worked night duty to ensure there were adequate staffing arrangements to meet the needs of residents.

There was a system in place to review and monitor the quality and safety of care and the quality of life of residents. Key quality indicator auditing was not up to date. Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored required review. Though audits had been carried out they were not carried out with enough frequency to give an accurate, contemporary account of care practices in the centre.

**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.

The guide included:

- (a) a summary of the services and facilities,
- (b) the terms and conditions relating to residence,
- (c) the procedure respecting complaints, and
- (d) the arrangements for visits.

Since the previous inspection the person in charge had enhanced the layout of the resident's guide to ensure it was in a more easy read format. Each resident had a written contract agreed on admission. The inspector noted a resident's guide was

available in residents' bedrooms.

Contracts reviewed dealt with the care and welfare of each resident in the centre. The contract set out where residents could find information on any extra fees that may be charged to them for example, cost of physiotherapy or occupational therapy.

**Judgment:**

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 is a registered nurse with the required experience in the area of nursing older people and worked full-time in the centre.

During the inspection she demonstrated her knowledge of the Regulations, the National Quality Standards for Residential Care Settings for Older People in Ireland and her statutory responsibilities.

The person in charge had maintained her continuous professional development having completed a Fetac Level 6 course in Managing People, 2012. She had also completed courses in 'recognising and responding to elder abuse in residential care settings', March 2013, 'wound assessment and classification', October 2014, 'current topics in nursing care', February 2014 and 'Understanding dementia', March 2014.

She had continued to attend seminars relevant to her role such dysphagia management, (managing the care needs for residents with difficulty swallowing and at risk of choking). The person in charge was observed frequently meeting with residents, visitors and staff throughout the days of inspection.

The person in charge had appropriate deputising 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:**

Records reviewed were maintained in a complete manner in the centre for the most part, however, staff files did not have all the information required as per Schedule 2.

Records were kept secure, while also being easily retrievable. The sample of records reviewed indicated records were accurate and up to date.

The person in charge confirmed her knowledge that general records, relating to complaints, records of visitors, duty rosters and fire safety training, tests and maintenance of fire fighting equipment were kept for not less than 4 years.

There were centre-specific policies, which reflected the centre's practice. Policies, procedures and practices were regularly reviewed to ensure the changing needs of residents were met.

The centre was adequately insured against injury to residents. Other risks were insured against, including loss or damage to a resident's property.

The person in charge had established and maintained a directory of residents for the designated centre and had kept it up to date.

A sample of staff files reviewed during the inspection indicated adequate vetting of staff working in the centre had been sought. Staff files contained the matters set out in Schedule 2 of the regulations apart from one file whereby a full employment history was not available for one staff member.

An individualised record of money logs or receipts was not maintained for residents when they used their 'pocket money' to purchase items. Therefore, improvements were needed to ensure residents personal money was robustly safeguarded against financial abuse.

**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 designed 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.

**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 were measures in place to safeguard residents and protect them from abuse. There was a policy and procedures in place for the prevention, detection and response to abuse. Staff were trained in the policy and procedures in place for the prevention, detection and response to abuse. 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 in line with the centre's policy.

There was a policy on, and procedures in place, for managing behaviour that is

challenging. Efforts were made to identify and alleviate the underlying causes of behaviour that is challenging. The person in charge had completed a training course in management of behaviour that is challenging in August 2012.

A restraint free environment was promoted. There was a policy on, and procedures in place, for the use of restraint. During the course of the inspection, the inspector identified the restraint policy had procedures in relation to the use of seclusion, however, the provider and person in charge identified seclusion was not used in the centre. Before the conclusion of the inspection the person in charge had re-drafted the policy which reflected the centre specific practices more accurately. Seclusion was outlined as not in use in the centre and the policy stated this.

Where restraint was used, it was in line with the national policy on restraint. A bedrail risk assessment had been drafted and was due to be 'rolled out'. The inspector reviewed a copy of the assessment. It assessed the level of risk associated without their use and the level of risk with their use. There was also a monthly restraint assessment that had been developed by the person participating in management, (PPIM). This captured information on the use of restraint for residents and review of restraint on a monthly basis. This was also due to be 'rolled out'.

There were systems in place to safeguard residents' money. Transactions and monies paid for services were maintained on a computerised system in the centre. Residents had independent control of their personal finances and had access to safe storage options in the centre. The person in charge and provider encouraged and promoted resident's independence as much as possible in this regard.

**Judgment:**

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 centre had policies and procedures relating to health and safety. There was an up-to-date health and safety statement. There was a 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.

Satisfactory procedures consistent with the standards published by the Authority were in

place for the prevention and control of healthcare associated infections.

There was an adequate supply of sinks for staff/residents and visitors to engage in hand washing. Alcohol hand gels were also located throughout the centre. These added to infection control and prevention measures. The flu vaccine had been made available to all staff and residents as per their consent. Colour coded mops and buckets were in use in the centre. Each colour code represented a specific area that mop was used in. This reduced the risk of cross infection.

Reasonable measures were in place to prevent accidents in the centre and grounds. Floor coverings were even, lighting in corridors, bedrooms and day/dining rooms was adequate. Grab rails were in place in areas such as corridors and stairs.

Environmental hazards had been identified with control measures in place. Doors to rooms that contained equipment or chemicals, for example, the laundry or clinical room, had control measures in place such as combination code locks to prevent entry to visitors and residents.

There was written confirmation from a competent person that all the requirements of the statutory fire authority were complied with. This was dated 10 October 2014.

There was adequate means of escape and fire exits were unobstructed. There was a prominently displayed procedure for the safe evacuation of residents and staff in the event of fire. Suitable fire equipment was provided. The fire alarm was serviced on a quarterly basis with the most recent 5 January 2015 and the previous service dated 1 October 2014. Fire safety equipment servicing was up to date, the most recent service dated December 2014.

Doors connected to the fire alarm system closed fully when the alarm sounded, demonstrating equipment used to contain a fire was fully functional. The inspector observed this to occur when the fire alarm was activated during a quarterly service on 5 January 2015.

The inspector identified, on the second day of inspection, that the ash trays in use in the smoking area required review. The inspector identified they could be knocked over and may not be entirely user friendly for residents with some dexterity or mobility issues. On the third day of inspection these ash trays had been replaced with a safer and easier to use option. Residents spoken with, that used the smoking room, told the inspector they found the new receptacles easier to use.

Staff spoken with, and a sample of records reviewed, indicated staff were trained and knew what to do in the event of a fire. There were fire drills at six monthly intervals and fire records were kept, which included details of frequency of fire drills, fire alarm tests, fire fighting equipment. However, there was no record of fire retardant furniture and bedding in the centre therefore the inspector could not review if bedding and furniture in use in the centre were fire safe, for example, chairs used in the smoking area.

The fire safety policy required review to ensure it gave adequate information to staff on all fire safety procedures and management that were in action in the nursing home at

the time of the inspection.

**Judgment:**

Substantially 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:**

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 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. A policy and self administration assessment was available to assess residents' capacity.

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.

A system was in place for reviewing and monitoring safe medication management practices. However, medication audits had not been carried out. This non compliance is addressed in Outcome 2 under Governance and Management.

**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 submitted to the Chief Inspector within three days as required.

Quarterly reports had also been submitted to the Chief Inspector within the specified time frames.

**Judgment:**

Compliant

**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):**

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

**Findings:**

The person in charge had arranged an assessment by appropriate nursing and 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 and choices.

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 and choices.

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, tissue viability nurse, dietician, speech and

language therapist (SALT) and physiotherapist.

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 pressures ulcers. Those identified at risk had risk reduction measures in place, such as pressure relieving mattress.

Evidenced based wound care interventions, prescribed by relevant clinicians, had brought about effective wound healing. Wound care plans were reviewed and updated after each dressing.

Care plans were reviewed on an ongoing basis or at a minimum of every four months. 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:**

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, independence and wellbeing in the most part. There was improvement needed to the door of a toilet located on the ground floor of the centre.

The premises and grounds were well-maintained with suitable heating, lighting and ventilation. The centre was homely with sufficient furnishings, fixtures and fittings. The centre was also clean and suitably decorated throughout.

The size and layout of bedrooms was suitable to meet the needs of residents with a sufficient number of toilets, bathrooms and showers. There were wash hand basins in each bedroom.

Shared rooms provided adequate screening to ensure:

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

There was a call bell system in place at each resident's bedside in both the single and twin rooms.

Residents had access to an enclosed garden on the ground floor of the centre. A smoking room was available to residents located on the ground floor.

There was a separate kitchen with sufficient cooking facilities and equipment on the ground floor.

The centre had previously been a Monastery. The original church with furnishings and fittings was connected to the centre and used by residents. The provider had moved some of the original wooden pews to make space for comfortable seating options for residents to sit on during Mass.

Equipment in the centre was fit for purpose and there was a process for ensuring that all equipment was properly installed, used, maintained, tested, serviced and replaced. The inspector noted maintenance records were documented and maintained. Equipment was stored safely and securely in the centre, for example, hoists and wheelchairs.

Handrails were provided in circulation areas. Grab rails were provided in bath shower and toilet areas. A lift was provided in the centre as residents were accommodated on more than one floor.

The door to a toilet located on the ground floor did not close properly without the door being pushed with force to lock the door. This required review and the inspector brought this to the attention of the provider. They gave assurances that this would be reviewed in early January 2015.

**Judgment:**

Substantially Compliant

***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:**

There were policies and procedures for the management of complaints. The complaints process was user-friendly, accessible to all residents and displayed in a prominent place inside the front entrance to the centre.

The complaints procedure outlined an independent appeals process with contact details given.

Residents were aware of the complaints process and were also supported to make complaints. Residents spoken with identified the provider, person in charge and person participating in management as persons they would feel comfortable in making a complaint to. There was a nominated person to deal with all complaints and all complaints were investigated. A record was made of all complaints, investigations, responses and outcomes.

There was a nominated person, separate to the person nominated to deal with all complaints, that had a monitoring role to ensure that all complaints were appropriately responded to and records were kept.

The complaints log was reviewed during the course of the inspection. There was evidence to show that the complaints procedure was implemented as documented and residents' satisfaction ratings were sought.

**Judgment:**

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):**

No actions were required from the previous inspection.

**Findings:**

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

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.

Religious and cultural practices were facilitated. Family and friends were facilitated to be with residents when they were dying. Arrangements for the removal of remains occurred in consultation with deceased resident's family where this was possible.

A sample of end-of-life care plans were reviewed they were detailed and documented

residents' social, spiritual and emotional needs. There was evidence to indicate residents and their families had been consulted with on a number of occasions to ensure their care plans were detailed and person centred.

**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:**

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

Residents had access to fresh drinking water which was supplied in their bedrooms, dining room and day rooms. The food provided met the dietary needs of each resident based on their nutritional assessment. Residents' nutritional risk had been assessed using a nutritional risk assessment tool. Residents identified at nutritional risk had been referred for dietician review and had been prescribed nutritional supplements and prescribed supplementation to their meals.

Residents with compromised swallow and at risk of choking had been referred to speech and language therapy (SALT). Those residents had received a review with a prescribed consistency meal planner in place, as necessary. The inspector observed modified consistency meal recommendations were being implemented for residents.

Food served during the course of inspection was nutritious, varied and available in sufficient quantities. Residents spoken with confirmed they enjoyed the food served in the centre and the inspector overheard residents complementing the food as they ate. There was a rotating menu with food choices available to residents to ensure mealtimes were interesting and enjoyable.

Meals and snacks were available at staggered intervals throughout the day. Generally, residents were offered assistance during meals in a sensitive, dignified manner. However, the inspector did observe staff assist one resident in a way that did not reflect best practice. This was brought to the attention of the person in charge who addressed the issue.

The allocation of staff duties during meal times needed to be reviewed and improved to

ensure staff were not engaged in other duties or tasks when designated to assist residents with specific care needs.

The inspector observed staff, who were sitting with residents assisting them with their meal, frequently leave the resident to get drinks and utensils for others who were also having their meals in the dining room. This impacted on the mealtime experience for the resident that required one to one assistance.

**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:**

The inspector was satisfied that residents living in the centre were afforded privacy, dignity and consultation in the most part. Though activities were provided for residents, they were not based on a meaningful activity assessment to ensure they met with residents' interests and capabilities. Not all residents in the centre had the opportunity to attend resident committee meetings.

Resident's religious and cultural preferences were catered for in the centre. The chapel was available for residents to use during Mass and Holy Days. Residents' voting rights were upheld and the provider ensured residents were supported to vote in local, national and European elections.

Interactions between staff and residents during the course of the inspection were observed to be respectful, for example, the inspector observed staff knocking on residents' bedroom doors before entering. Staff spoke with residents in a pleasant and caring way that expressed genuine warmth.

Residents had access to private telephone calls if they wished and the centre had adequate space for residents to meet visitors in private. Visiting times were not restricted and a visitors' sign in book was well maintained and located at the main reception.

A CCTV system was in use to control the perimeter of a building and reception areas for

security purposes. There was a centre-specific policy on CCTV detailing the specifics of its use. CCTV was not in use in bedrooms or bathrooms.

Residents had opportunities to attend resident committee meeting in the day centre which was also part of the designated centre. However, residents that did not attend the day centre did not participate in resident committee meetings. The person in charge had contacted an advocacy group and was in the process of setting up facilitated visits to the centre by an independent advocate, who would facilitate residents' committee meetings.

Residents participated in Sonas, a therapeutic activity for residents with dementia and/or cognitive decline. This was provided each week and the person in charge, provider and person participating in management had also completed courses in Sonas. There was informative signage of activities and upcoming events located throughout the centre.

Other activities, such as music sessions and group exercises occurred in the centre. However, activity assessments in residents' care plans were not comprehensive. Improvement was necessary to ensure meaningful social care assessments were carried out. This would ensure activities provided were in accordance with residents' interests and capabilities. The person in charge planned to carry out meaningful activity assessments in the new-year for all residents in the centre.

**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:**

There was a policy on residents' personal property and possessions. A record was kept of each resident's personal property. Personal property was safeguarded through record keeping. An inventory of residents' belongings was taken on admission.

There were adequate laundry facilities with systems in place to ensure that residents' own clothes were returned to them. The location of the laundry facilities meant residents clothes could be dried on a washing line or using mechanical means as required. Residents' clothes were also ironed when required.

However, from the sample of records documented they were not updated with enough

frequency. For example, a resident's inventory of personal property was dated August 2011.

Some detail of items, in the inventories documented, required review as they did not provide the reader with enough description of residents' personal belongings should they go missing.

**Judgment:**

Substantially 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):**

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

**Findings:**

Staff had opportunities to receive training specific to their role. From staff files reviewed the inspector noted staff had received mandatory training in for example, elder abuse prevention, response and detection training, fire safety, manual handling and medication management training where appropriate.

There was an actual and a planned staff rota in operation which accurately reflected the staff on duty at the time of inspection. The duty roster indicated there were sufficient numbers of staff to meet the assessed dependency needs of residents from the staffing rosters reviewed as part of the inspection. The person participating in management worked on night duty, at the time of inspection, to fill a post that was available due to staff shortages and ensure residents' continuity and quality of care were not impacted upon.

**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:***

Ann-Marie O'Neill  
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>

<b>Centre name:</b>	Corrandulla Nursing Home
<b>Centre ID:</b>	OSV-0000332
<b>Date of inspection:</b>	10/12/2014, 11/12/2014 and 05/01/2015
<b>Date of response:</b>	12/02/2015

### 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:

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored required review. Though some audits had been carried out they were not carried out with enough frequency to give an accurate, contemporary account of care practices in the centre.

#### Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

A personal assistant has been hired to free up time for the PIC and Manager, facilitating the Auditing Processes and ensuring that the Audits are carried out in a more timely and effective manner.

Proposed Timescale: 16/02/2015.

**Proposed Timescale:** 16/02/2015

**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:**

An individualised record of money logs or receipts was not maintained for residents when they used their 'pocket money' to purchase items as set out in the matters of Schedule 3, 5 (b)(i).

**Action Required:**

Under Regulation 21(3) you are required to: Retain the records set out in Schedule 3 for a period of not less than 7 years after the resident has ceased to reside in the designated centre.

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

While we record all money given/returned to a resident, we do not routinely monitor their spending. We will issue Receipt/Note Books to all residents in receipt of monies.

We will ask their permission to document their spending in their notebook or ask that they do so. We will advise the residents to ask for a receipt whenever they make a purchase and to document it in their Notebook (or have us do so for them).

We will ensure that staffs, using a residents' money to make a purchase on the residents' behalf, continue to give a receipt for the purchase, as well as all the change, but to ensure that they also document the purchase in the residents' Notebook.

Each week we will ask residents to allow us to review their Notebook to check its consistency/tally and identify any issues.

Proposed Timescale: 06/03/2015.

**Proposed Timescale:** 06/03/2015

**Theme:**

Governance, Leadership and Management

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

One staff file reviewed did not have included a full employment history for the staff member.

**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:**

Hayden Healthcare Limited apologises for this oversight and will identify and approach the relevant staff member to correct the issue identified.

**Proposed Timescale:** 15/02/2015

**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:**

There was no record maintained of fire retardant furniture and bedding in the centre therefore the inspector was unable to review if fire safe bedding and furniture was in use in the centre.

**Action Required:**

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

While our Fire Retardant Furniture have their Fire Retardant properties displayed on their labels we do not maintain a register of our Fire Retardant Fixtures and Fittings.

This will be rectified with a Book/Ledger inventorying the same.

All future purchases of furniture and bedding will have their Fire Retardant properties logged in this book also. We will remind staffs NOT to remove any labels from furniture which may be used to identify their Fire Retardant properties.

**Proposed Timescale:** 23/02/2015

**Proposed Timescale:** 23/02/2015

**Theme:**

Safe care and support

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

The fire safety policy required review to ensure it gave adequate information to staff on all fire safety procedures and management that were in action in the nursing home.

**Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

The Fire section of the Emergency Policy and Procedure will be updated to reflect current training and practice.

We will also reproduce the Fire section as a separate Policy and Procedure to help staffs locate that particular policy more efficiently.

Proposed Timescale: 20/02/2015

**Proposed Timescale:** 20/02/2015

**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:**

A door to a toilet located on the ground floor of the centre required improvement to ensure it closed properly with minimum effort required.

**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 toilet door initially had its' closer reset to close the door more completely 28/12/2014, but residents found it too difficult to negotiate independently and it needed to be reset to its original "weaker" setting.

We have since replaced the door and its closing mechanism completely. No issues have

been noted or reported with this new door.

Proposed Timescale: 06/01/2015

**Proposed Timescale:** 13/02/2015

### **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:**

The person in charge had not ensured an adequate number of staff are available to assist residents at meals, as was observed during the course of the inspection.

**Action Required:**

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

While the numbers of staff available for work were adequate for the tasks required, we acknowledge that their distribution and work prioritising was substandard at that time. We will remind the supervising Staff Nurses to prioritise workloads and allocate their staffs more diligently in the future and we will reinforce it further in a series of Staff Meetings and spot checks at meal times.

Proposed Timescale: 19/02/2015.

**Proposed Timescale:** 19/02/2015

### **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:**

Activity assessments in residents' care plans were not comprehensive. Improvement was necessary to ensure meaningful social care assessments were carried out.

**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:**

There are no documented Activity Assessments in our residents care plans, but these

were components of the residents Activities of Daily Living assessments. A more focused/specialised tool (Meaningful Activities Assessment – Pool Activity Level PAL Checklist has been sourced and is now being rolled out for each resident.

The PAL Checklist document was sourced 02/01/2015 and adapted to the residents needs 07/01/2015. It was implemented 08/01/2015 and we expected each resident to have their individual PAL Checklist completed by 16/02/2015.

Proposed Timescale: 16/02/2015.

**Proposed Timescale:** 16/02/2015

**Theme:**

Person-centred care and support

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

Residents, that did not attend the day centre, did not participate in resident committee meetings.

**Action Required:**

Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

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

Hayden Healthcare Limited has no input/influence into the make-up/organisation/activity of the Residents Committee as a means of ensuring we did not unduly put pressure on or influence its activity. The Person in Charge (PiC), A. Abed had already identified a lack of participation opportunity by some residents and had been in the process of seeking outside Advocacy group input to address this issue by the time of the HIQA inspection. There are, without question, residents who do not attend the Activity Centre not being afforded the opportunity to participate in the Residents Committee Meetings. The PiC will also commence in-house meetings for residents until the advocate group sources a person for us.

Proposed Timescale: The members of the Residents Committee have been spoken to (07/01/2015) and told to ensure a more inclusive representation of our residents.

The PiC had followed up on her enquiry re: Advocate Group input (07/01/2015) and they have yet to allocate a suitable person. An advocate representative availability date/schedule of attendance is still pending and will be followed-up each week by the PiC until a result is forthcoming.

**Proposed Timescale:** 30/05/2015

**Outcome 17: Residents' clothing and personal property and possessions**

**Theme:**

Person-centred 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 not ensured personal property inventories were updated with enough frequency and detail to ensure each resident had retained control over his or her personal property and possessions.

**Action Required:**

Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

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

While each resident had their own property list they did not have sufficient detail, or were not updated regularly enough to have any practical use outside of their initial creation. We acknowledge that the circumstances/reasons for this are irrelevant and that this failing needs to be addressed and the documents relevance maintained. We have created a new Property List which has been viewed by the HIQA inspector and deemed acceptable at this time. It will be used to document the residents clothing/belongings to the level required.

Proposed Timescale: The new Property List document was created by 02/01/2015, initiated by 09/01/2015 and is currently in the process of being rolled out through all our residents. It is a large task but we hope to have all personal possessions documentation completed by 30/03/2015.

**Proposed Timescale:** 30/03/2015