<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Francis Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000393</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Kilkerrin, Ballinasloe, Galway.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>094 965 9230</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:stfrancishomekilkerrin@eircom.net">stfrancishomekilkerrin@eircom.net</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>John Desmond Joyce &amp; Sharon Joyce Partnership</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Hilda Joyce</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Lorraine Egan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>27</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>7</td>
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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.
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 2 day(s).

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

From:  
14 October 2014 09:00  
15 October 2014 09:00

To:  
14 October 2014 18:45  
15 October 2014 18:25

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

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

The purpose of this inspection was to monitor the centre's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and to inform a registration renewal decision.

As part of the inspection, the inspector met with residents, staff, the clinical nurse manager, the person in charge and the newly appointed provider nominee (hereafter called the provider). The inspector observed practices and reviewed documentation such as policies, care plans, medical records, audits, training records and staff files. In addition, the inspector received and reviewed resident and relative questionnaires.

Throughout the inspection, the person in charge demonstrated competency in her
role. Both the person in charge and the provider demonstrated knowledge of their responsibilities as required by the Regulations.

The feedback from families was one of satisfaction with and praise for the care provided and residents echoed these sentiments. Residents spoken with said they felt safe, were listened to and enjoyed the activities provided in the centre. In addition, residents were complimentary of the food and of the staff working in the centre.

The inspector found good practice in areas such as the provision of access to allied health professionals, the management of behaviours that challenge and the decrease in the use of restraint in the centre. However, improvements were required including some significant issues which needed to be addressed. The inspector issued three immediate actions in relation to risks associated with the window openings, the ineffective thermostatic control measure and internal fire doors, which did not provide adequate protection in the event of a fire in the centre. The immediate actions are included in the action plan under Regulation 26 (1)(a), Regulation 26 (1)(b) and Regulation 28 (1)(a).

Improvement was also required in the following areas:

- the information contained in the statement of purpose,
- reviewing and improving the quality and safety of care in the centre,
- the implementation and review of a number of policy documents and procedures,
- the identification and management of some risks,
- the measures in place to ensure residents could be evacuated from the centre in the event of an emergency,
- the procedure for identifying and responding to complaints,
- the assessment of residents' wishes for their end of life care,
- documentation pertaining to modified consistency diets,
- access to independent advocacy services.

The findings are discussed in the report and the actions required and the provider's responses are included in the Action Plan at the end of the report.
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 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 consisted of a statement of the aims, objectives and ethos of the designated centre. It required review as the centre's registration number, date of registration and expiry date of registration was inaccurate.

The statement of purpose provided a clear and accurate reflection of the facilities and service provided for residents.

The services and facilities outlined in the statement of purpose, and the care provided, reflected the different needs of residents.

**Judgment:**
Non Compliant - Minor

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**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:**

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The management structure was clear and showed the lines of authority and accountability in the centre. However, the centre’s auditing and monitoring processes needed to be improved.

The centre had appointed a new provider nominee (provider). She had worked in the centre as a general manager for a number of years. The provider and person in charge were responsive throughout the inspection. They addressed areas of concern brought to their attention. For example, the provision of a lock on the sluice room door.

The provider and person in charge had carried out audits in a number of areas, for example medication management and the use of physical restraint. However, not all audits had the date evident so it was not clear when some audits had taken place.

Both the provider and person in charge told an inspector that they reviewed the audits and identified areas for improvement. However, identified areas of concern had not been addressed. For example, the inspector identified areas of immediate risk, which were detailed in the centre's audit and had not been addressed. There was no plan in place to address identified risks and the provider was not clear regarding when the identified risks would be addressed.

The inspector issued two immediate actions relating to items, which had been identified in an audit but had not been addressed. These related to the measures in place to control the temperature of the water and the lack of window restrictors in the centre. These are discussed further under Outcome 8: Health and Safety and Risk Management.

The completion of an auditing tool used by the centre needed to be improved. It did not always identify the person completing the audit and some parts of the audit were not completed accurately. In addition, some information was not accurate as the provider and person in charge were not aware of some control measures in place to address identified risks.

There was no documented annual review of the quality and safety of care delivered to residents in the centre and the reviews carried out had not taken place in consultation with residents and their families.

**Judgment:**
Non Compliant - Moderate

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**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

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

**Findings:**
The inspector viewed a sample of resident contracts. Contracts had been agreed with the resident within one month of admission to the centre and clearly set out the fees to be charged and the services provided.

There was a guide for residents which included a copy of the centre's statement of purpose, a brochure which outlined the facilities and services provided, a sample contract of care, a sample menu, the most recent inspection report and the Authority's contact details.

**Judgment:**
Compliant

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**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 centre was managed by a registered nurse with experience in care of the elderly. She had been person in charge of the centre since 2012 and she was knowledgeable of the residents' needs, clinical care and her statutory responsibilities.

She was engaged in the governance and operational management of the centre alongside the provider. The inspector observed her interacting with the residents and it was clear the residents knew her well. Residents and families spoken with said they would speak with her if they had any concerns.

**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:**
The centre did not have all the written policies and procedures required by the Regulations. Some policies required review to ensure they were centre specific and provided clear guidance for staff.

The centre did not have a policy on self-administration of medication or for staff training and development.

The centre was using the HSE policy on the use of restraint which had not been reviewed to ensure it was applicable to this centre.

The policy on the prevention, detection and response to abuse required improvement. It did not outline the response to be taken if an allegation of abuse was made against a member of the management team or the Liaison Officer. In addition, the policy did not outline the timelines of an investigation into an allegation of abuse.

Not all staff had signed to indicate they had read, understood and agreed to adhere to the policies and procedures.

A sample of staff files were reviewed. The files required improvement as they did not contain all items required in the Regulations, for example evidence of Garda Vetting, a full employment history and a written reference from the employee's most recent employer was not evident in all files.

Improvements were required to the staff rota as abbreviations were used on the rota and there was no indication as to their meaning and therefore the roster was unclear.

The centre was insured against accidents or injury to residents, staff and visitors.

**Judgment:**
Non Compliant - Major
### 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 her responsibility to notify the Authority if the person in charge was absent from the centre for 28 days or more.
- The clinical nurse manager takes the role of person in charge of the centre in the absence of the person in charge.
- The person in charge and provider were available if staff needed support in the evenings and at weekends.

**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:**
- The policy on the prevention, detection and response to abuse needed to be improved. It did not give clear guidance on the measures to be taken if the nurse in charge received an allegation of abuse. The provider and person in charge were clear regarding the measures to be taken if the alleged abuser was a member of staff however, not all staff were aware of this procedure.
- Staff had received training in recognising and responding to allegations of abuse. Staff spoken with were clear regarding reporting to the nurse in charge if they suspected,
witnessed or received an allegation of abuse.

The use of restraint in the centre was documented and a register of the duration and release times was maintained. There had been a reduction in the use of physical restraint in the centre. Measures such as low low beds and crash mats had been used to reduce the number of residents using bed rails.

Staff had received training in responding to behaviours that challenge. There had been a reduction in behaviours that challenge for some residents living in the centre. Chemical restraint had been prescribed for some residents. The staff nurse spoken with was clear regarding the circumstances in which this PRN (as required) medication would be used and records showed that the medication was not administered on a regular basis. However, there were no written guidelines outlining the circumstances in which this medication would be administered and the preventative measures which could be taken to prevent use of chemical restraint.

**Judgment:**
Non Compliant - Minor

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

**Findings:**
The centre had policies and procedures in place to protect and promote the health and safety of residents, staff and visitors. However, significant improvement was required to the measures in place to protect residents in the event of a fire in the centre and to the identification and management of risks. Three immediate actions were issued in relation to risks in the centre.

Emergency Procedures:

There was an emergency procedure in place which needed to be improved. For example, it stated that portable heaters would be available in the event of a loss of heating however, the location of the heaters was not detailed. In addition, the procedure referred to a generator and the centre did not have a generator on site.

The missing persons’ procedure needed to be improved. It did not clearly state the area referred to as the neighbourhood and did not outline the time after which the missing
resident’s family and the Gardaí would be contacted.

An emergency box was in place. The box was not stored in the room detailed in the procedure. The box contained details of all residents, high visibility jackets and torches. There was no system for checking if the items were present and working. The inspector found that the torches were not working.

Fire Safety and Management:

The procedure to be followed in the event of a fire was displayed. Fire fighting equipment had been serviced. A monthly fire safety checklist showed that fire extinguishers were in place and the external fire doors could be opened from the inside.

Records showed that fire drills had taken place however, improvement was required to the frequency of fire drills and to actions to be taken in response to findings from fire drills. Eight fire drills had taken place since June 2014 however, no fire drills had taken place between July 2013 and May 2014.

A system for ensuring a staff member took charge in the event of a fire had been introduced. A care assistant took the role of fire marshal and this was detailed in the clinical room on a daily basis.

The inspector found that some items such as the necessity for more wheelchairs to assist in the evacuation of residents from the centre had been addressed. However, there was no evidence that all identified issues had been addressed. For example, a couch was found blocking a doorway on two consecutive fire drills and fire marshals had responded inappropriately to the fire drill on some occasions. The recommendation for weekly fire drills and for more frequent fire drills for staff working nights had not been addressed.

There was no evidence that all staff had taken part in a fire drill. The names of staff who attended had not been maintained on most fire drill records.

Not all staff had received training in fire prevention.

The internal fire doors in the centre did not provide adequate protection in the event of a fire. Some doors did not close when the fire alarm was activated. There was no evidence the fire alarm was tested. Some fire doors did not contain intumescent strips and others did not contain full intumescent strips. In addition, some sitting room and bedroom doors were being inappropriately held open by objects. The inspector issued an immediate action plan.

The form submitted with the centre's application to renew the registration of the centre had not been signed by a suitably qualified person. This was brought to the provider’s attention prior to the inspection and the provider was requested to resubmit the form signed by a suitably qualified person. On the day of the inspection the provider had a form signed by a suitably qualified person.
Risk Management:

There was no procedure outlining the measures to control the risks associated with accidental injury to residents, visitors or staff, aggression and violence or self-harm. There was no written procedure outlining the arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

The inspector viewed the risk register. The centre had carried out a wide range of risk assessments. However, there was no plan in place to address some identified risks. For example, two immediate risks identified by the inspector had been identified in September 2014 and had not been addressed. The provider was not clear regarding when identified risks would be addressed.

The temperature of the water posed a risk of scalding. The provider and person in charge were not aware that thermostatic control measures were in place. An immediate action plan was issued as the control measure in place was not effective.

Window restrictors had not been fitted to windows which posed a risk to residents. This had been identified in the risk register in September 2014 and had not been addressed. The inspector issued an immediate action plan.

The lock on the sluice room door was easily accessible to residents and this had not been risk assessed. The inspector brought this to the immediate attention of the provider who changed the lock on the sluice room door on the day of the inspection.

Residents were evacuated to the enclosed garden in the event of a fire or emergency. However, there was no safe exit from the enclosed garden to the front of the building in the event residents were evacuated in an emergency and could not re-enter the building.

A record of accident, incidents and near misses was maintained. However, a complaint had been recorded as a near miss and had not been identified as a complaint. This is discussed further under Outcome 13: Complaints procedures.

Infection Control:

An audit carried out by the person in charge showed that there was no documented system for responding to an outbreak of infection. There was no evidence this had been addressed.

Staff were knowledgeable of infection control measures including the segregation of laundry and disposal of waste.

The provision of hand sanitising gel required improvement as the location of dispensers was not easily accessible to all resident bedrooms.
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):
No actions were required from the previous inspection.

Findings:
There was a policy and procedures for prescribing, administering, recording, storing and disposing of medication.

A sample of medication prescription sheets were viewed. Medications were administered in line with the prescription and the recording sheet was signed by nurses.

A sample of residents' medication was viewed. Medications were stored in the centre's clinical room and the nurse on duty held the keys.

There were no measures in place to ensure medications which needed to be discarded after being open for a specific period of time were discarded. It was not clear if a medication in use was being used passed the use by day.

A sample of PRN (as required) medications were viewed by the inspector. The nurse on duty was clear regarding the circumstances in which medications to be used in the event of a specific medical emergency would be administered. However, written guidelines were not adequate as they did not clearly outline the response to be taken.

The fridge for storing medication which needed refrigeration was viewed. The temperature of the fridge was recorded on a daily basis. Medications requiring temperature control were stored in the fridge.

The procedures for storing medication which required specific control measures was viewed. The medication was stored securely and the staff nurse said it was counted by two nurses at the change of each shift.

Medication audits had been carried out by the pharmacy which supplied the centre's medication.

Judgment:
Non Compliant - Minor
### 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.

<table>
<thead>
<tr>
<th>Theme: Safe care and support</th>
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<tbody>
<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong> No actions were required from the previous inspection.</td>
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<tr>
<td><strong>Findings:</strong> Notifications had been submitted to the Authority as required and the person in charge and provider were aware of their responsibilities in relation to notifications.</td>
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<td><strong>Judgment:</strong> Compliant</td>
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### 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.

<table>
<thead>
<tr>
<th>Theme: Effective care and support</th>
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<tbody>
<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong> The action(s) required from the previous inspection were satisfactorily implemented.</td>
</tr>
<tr>
<td><strong>Findings:</strong> Residents were supported to access allied health professionals as required and had a choice of remaining with their current GP or the centre would support residents to choose a GP. Access to a range of allied health professionals such as speech and language therapy, chiropody and occupational therapy was provided by the centre. A range of assessments had been carried out which informed care plans. Areas such as residents' risk of developing pressure ulcers, risk of falling, moving and handling assessments and oral hygiene assessments had been carried out. Care plans had been put in place for identified needs. However, some improvement was required as not all identified interventions had been responded to. For example, access to physiotherapy was identified as a required need for a resident but this had not been facilitated as outlined in the care plan. The centre had employed a social care worker as an activities coordinator to deliver</td>
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activities to residents. The activities coordinator was implementing activities based on residents' identified needs and preferences. Residents spoken with said they liked the activities.

Judgment:
Non Compliant - Minor

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 centre was a monastery which had been modified for use as an older persons centre. It included a church, two sitting rooms, a dining room, a room for residents to meet with visitors in private and single, twin and multi occupancy bedrooms. It was clean and well maintained throughout.

Residents’ bedrooms were located on the ground and first floor of the building with single, twin and one multi occupancy room in use. The multi occupancy room did not comply with the Regulations in regard to the physical environment of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and Standard 25 of the National Quality Standards for Residential Care Settings for Older People 2009 as will be required by July 2015. The provider stated her intention to liaise with the Authority regarding the continued use of this room.

Bedrooms had call bell facilities and residents had personalised their bedrooms with photos of their loved ones. The dining room, sitting rooms and visitor's room were located on the ground floor of the centre.

Improvement was required to the call bell system as not all call bells were working. The inspector found that a call bell was not working in an assisted bathroom.

Not all residents had access to lockable storage in their bedrooms.

The saddle boards at the entry to the sitting rooms resulted in some difficulty for residents accessing and exiting the sitting rooms when using assistive equipment such as walking aids. This had been identified in a risk assessment in September 2014 and
had not been addressed.

There was a shaft lift which allowed residents who could not use the stairs to access the first floor of the centre.

There was appropriate assistive equipment provided to meet the needs of residents. The inspector viewed the maintenance and servicing contracts and found the records were up to date and confirmed that equipment was in good working order.

Handrails were provided throughout the centre and residents were observed using the handrails. Seating was available throughout the centre.

An accessible enclosed garden was available for residents use. The inspector spoke with some residents who said they liked to sit in the garden.

There was no assisted bath in the centre however, residents spoken with and care plans viewed showed that residents preferred to use an assisted shower.

Judgment:
Non Compliant - Minor

**Outcome 13: Complaints procedures**

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**
Person-centred care and support

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

**Findings:**
The inspector reviewed the complaints procedure and the management of complaints in the centre and found that there was a system in place for managing complaints. However, improvements were required to the complaints procedure and to some documentation.

The log book detailing complaints received in the centre was reviewed. The inspector found that complaints were managed appropriately and in a timely manner. However, improvement was required to the identification and understanding of complaints in the centre. The inspector found details of a complaint documented in the centre’s log for recording near miss incidents. There was no evidence this complaint had been addressed.

The complaints procedure required improvement. The procedure inappropriately detailed abuse, exploitation, assault or neglect as complaints which should be addressed to the
Authority, the HSE or the Gardaí. In addition, the procedure did not outline who would be responsible for investigating complaints if a complaint was received in relation to one of the centre's named investigative team.

There was no independent person specified with a monitoring role to ensure that complaints were responded to and records maintained.

A condensed version of the complaints process was on display. It needed to be improved as the contact details of the person who complainants could contact if they wished to appeal the findings was not included.

**Judgment:**
Non Compliant - Moderate

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**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:**
The centre had a policy and procedures in place for end of life care. Access to palliative care was facilitated and encouraged where appropriate. Residents were supported to receive appropriate religious sacraments such as the Sacrament of the sick for Roman Catholic residents. However, the arrangements in place for eliciting residents' wishes for end of life were not adequate.

The inspector found that the centre was providing appropriate care and comfort to residents at end of life. The care provided considered residents' physical, emotional and spiritual needs. However, residents' end of life wishes had not been assessed and it was therefore difficult to ascertain if the centre was meeting residents' wishes in regard to their wishes for end of life care and support.

The person in charge stated that the centre was in the process of eliciting residents' wishes for their end of life. There was evidence that the centre had discussed end of life wishes with residents at a resident meeting which took place in September 2014. Some initial one to one meetings with residents had taken place and the centre had been in contact with residents' next of kin in relation to end of life care and wishes.

The centre had a chapel which was used for funerals, months mind masses and remembrance ceremonies following the death of a resident. There was evidence families were encouraged and facilitated to attend the centre following the death of their loved
one and appropriate support was provided to families. The provider told the inspector that residents were facilitated to attend residents' funerals and that staff provided a 'guard of honour' at the funeral of residents.

**Judgment:**
Non Compliant - Moderate

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**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

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

**Findings:**
There was a policy and procedures in place to ensure residents were supported to experience good nutrition and hydration. A sample of resident care plans were viewed, which showed that residents had been referred for nutritional support where required and documentation was maintained of residents' dietary intake where appropriate.

Mealtimes took place in the dining room or in residents’ bedrooms if the resident preferred. The dining room was bright, warm and suitably decorated and the atmosphere was one of a social occasion. A choice of meals was available and extra portions were offered to residents.

The inspector sampled the food and found it was flavoursome, suitably heated and nicely presented. Residents spoken with stated they enjoyed the food. Assistance offered during mealtimes was discrete and respectful. The menu was a three week rolling menu and was based on residents’ preferences.

A weekly menu was displayed on the tables and on the wall in the dining room and on the wall outside the kitchen. The menu required some amendment to ensure that residents were aware of the choice of meals. The display of the weekly menu rather than a daily menu could be confusing and there was no pictorial menu in place for residents who could not read the menu.

Snacks and drinks were available throughout the day and residents’ dietary requirements were catered for. An inspector met with the chef and noted there were adequate supplies of fresh and frozen food. The chef and kitchen staff had access to all relevant information about residents' assessed diets. However, documentation of modified consistency diets required improvement as different terminology was in use in the centre and in some care plans, which could increase the risk of residents receiving
diets inconsistent with their assessed needs.

Judgment:
Non Compliant - Minor

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:
There was evidence that residents were consulted in relation to how the centre was run and that residents’ feedback was sought which informed practice in the centre.

There was a residents’ committee and meetings took place on a regular basis. A range of different items were discussed at the meetings. The committee had appointed four residents to act as representatives for the residents in consulting with management about the running of the centre.

The residents had implemented a recycling committee and there was evidence residents were actively involved in ensuring items were recycled where possible.

There was a cordless phone available for residents to make or receive phone calls in private and a room was available for residents to meet with visitors in private. The centre provided local and national newspapers and televisions and radios were available for residents to use.

The centre provided care assistants to accompany residents to hospital in the event of an emergency. Family members spoken with told the inspector that the centre had provided additional staffing in the hospital setting until such time as the resident was discharged from the hospital.

Residents were registered to vote and were facilitated to vote in the local polling centre.

Staff were observed knocking before entering residents’ bedrooms. However, bathroom and bedroom doors did not have locks.

The centre had a Liaison Officer who provided advocacy for residents. However, there
was no independent advocacy service available for residents to access.

The inspector observed staff providing assistance and support to residents in a way which respected their dignity. However, the language used in some documentation required improvement. For example, bed rails were referred to as cot sides.

**Judgment:**
Non Compliant - Moderate

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**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.

The inspector viewed the laundry facilities and the systems in place to ensure residents clothes were returned to them. The laundry facilities were adequate and laundry staff spoken with were knowledgeable of systems to ensure clothing was laundered and measures to be taken in the event a resident had an infectious disease.

**Judgment:**
Compliant

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**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 viewed the staff rota and observed staffing levels over the two days of the inspection. The person in charge stated that staffing levels and skill mix were reviewed regularly and adjusted in response to residents’ needs.

Training records showed that staff had undertaken training in a variety of areas relevant to their roles including all mandatory training. A training plan outlining areas of training for staff was in place.

Records showed that staff appraisals and staff meetings had taken place.

Staff spoken with were knowledgeable of residents' needs and the measures to be taken if they received an allegation of abuse or a complaint.

Staff files and the staff roster required improvement. These items are discussed under Outcome 5: Documentation to be kept at a designated centre.

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:
Lorraine Egan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>St Francis Nursing Home</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000393</td>
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<tr>
<td>Date of inspection:</td>
<td>14/10/2014</td>
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<td>Date of response:</td>
<td>30/12/2014</td>
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Requirements

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

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not contain the accurate registration number, date of registration and expiry date of registration of the centre.

Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The accurate registration number, date of registration and expiry date of registration was amended on the statement of purpose.

Proposed Timescale: 16/12/2014

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no documented annual review of the quality and safety of care delivered to residents in the centre.

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

Please state the actions you have taken or are planning to take:
The centre has an audit tool to audit all areas as outlined in the HIQA standards. The outcomes from this audit will be compiled into a report.

Proposed Timescale: 31/03/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The reviews carried out had not taken place in consultation with residents and their families.

Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
The above mentioned report will be made available and discussed with residents and family during the first quarter of each year.
Proposed Timescale: 31/03/2015

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management systems were not effective in areas such as risk identification and action and auditing and review.

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

Please state the actions you have taken or are planning to take:
The Centres next internal environmental audit is scheduled to commence March 2015, compulsory training will be provided to auditors to ensure all audits are completed accurately, dated and signed by auditor.
Internal environmental audits are carried out 6 monthly, high risk actions are addressed immediately. Low and medium risks are discussed at monthly management meeting; Our risk register has been updated to include action ‘planned completion dated’, ‘review date’ and ‘actual completion date’.

Water temperature checks are carried out to ensure the thermostatic controls are operating effectively.

Proposed Timescale: 26/11/2014

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy on the prevention, detection and response to abuse did not outline the response to be taken if an allegation of abuse was made against a member of the management team or the Liaison Officer. In addition, the policy did not outline the timelines of an investigation into an allegation of abuse.

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

Please state the actions you have taken or are planning to take:
Policy will be updated to outline the response to be taken if an allegation of abuse was
made against a member of the management team or the Liaison Officer and the timelines of an investigation into an allegation of abuse.

**Proposed Timescale:** 07/12/2014  
**Theme:** Governance, Leadership and Management  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Not all policies as required by the regulations were in place.

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

**Please state the actions you have taken or are planning to take:**  
Staff training and development policy has been developed.
Policy on self-administration of medication will be developed and all staff will be trained on all policies.

**Proposed Timescale:** 15/12/2014  
**Theme:** Governance, Leadership and Management  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Staff files did not contain all items required in the Regulations.

Abbreviations were used on the staff roster and there was no indication as to their meaning and therefore the roster was unclear.

**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:**  
Full review of staff files will take place and be discussed with each staff member during their annual appraisal, gaps will be identified and plan put in place for each staff member where documents are required.

All Abbreviations are now explained on the rota.

**Proposed Timescale:** 31/12/2014
Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were no written guidelines outlining the circumstances in which chemical restraint would be administered and the preventative measures which should be taken prior to the use of this PRN (as required) medication.

Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
• An individual written protocol will be developed for each resident who is on chemical restraint, after discussion with the MDT, explaining the circumstances, calming measures that can tried prior to the administration of medication and post sedation care, same will be attached to the residents care plan and medication kardex for review for all the nurses prior to the administration. Same will be reviewed by the medical team, and by the pharmacist every three month or as needed.
• The administration of drugs will be guided by the nurses observation of the clinical circumstances of the resident and by any request of the individual resident for the particular PRN medication(such as the need for pain relief)
• PRN medications should not be offered or given only at the times listed on the medication administration record or at specific medications rounds. As it is for occasional use, the resident should be offered the medications at the times they are experiencing the symptoms either by telling a member of staff or by staff identifying the residents need as outlined in the care plan. The exact time the medication was given and the amount given should be recorded on the medication administration record.
• Residents care plan to update to demonstrate that staff know what the medication is for and have made an assessment on whether the person requires the medication.
• The medication kardex will be update with the interval, frequency and maximum dose in 24 hours.

Proposed Timescale: 07/12/2014

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff were aware of the procedure in relation to the prevention of abuse.

Action Required:
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.
Please state the actions you have taken or are planning to take:
The policy on the prevention, detection and response to abuse will be updated to give clear guidance on the measures to be taken if the nurse in charge received an allegation of abuse. All staff will be trained on the policy.

Proposed Timescale: 31/01/2015

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:
Immediate Action Plan: The control measure in place to control the temperature of the water was not effective. The temperature of the water posed a risk of scalding.

The system in place for the identification and control of risk was not adequate.

Action Required:
Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
On the first day of inspection the water temperature was reduced and an immediate check was carried out on all water outlets including sinks, baths and showers. Daily water checks were carried out for a four week period to ensure the thermostatic controls are operating effectively. After four weeks of consistent temperatures that did not exceed 43 degrees Celsius the frequency of the checks was reduced to weekly checks, we will continue to do weekly checks at the centre.

The centre carries out internal environmental audits every 6 months and the data/findings are recorded on the centres risk register. The last environmental audit was carried out in September 2014 and the next environmental audit is scheduled for March 2015. The strategy for dealing with risks identified is (a) Eliminate (b) reduce or (c) Manage. On completion of the audit any High risks are actioned are addressed immediately. During the six months between audits all Low and medium risks are discussed at monthly management meeting the strategy is agreed and an action identified.

Our risk register has been updated to include ‘action planned completion dated’, ‘review date’ and ‘actual completion date’. These dates will be agreed and recorded at our monthly management meeting.

A system for documenting and responding to an outbreak of infection will be developed.
To eliminate the risk of contamination due to crushing tablets each resident now has their own mechanism for crushing tablets.

**Proposed Timescale:** 31/01/2015  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Immediate Action Plan:  
Window restrictors had not been fitted to windows which posed a risk to residents.

**Action Required:**  
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

**Please state the actions you have taken or are planning to take:**  
Window restrictors have now been fitted to windows.

**Proposed Timescale:** 29/10/2014  
**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The missing persons’ procedure did not clearly state the area referred to as the neighbourhood and did not outline the time after which the missing resident’s family and the Gardaí would be contacted.

**Action Required:**  
Under Regulation 26(1)(c)(ii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.

**Please state the actions you have taken or are planning to take:**  
The missing persons’ Policy has been updated to clearly state the area referred to as the neighbourhood.  
A missing person drill was carried out at the centre with the maximum number of staff on duty and the minimum number of staff on duty to calculate the centres search/response time to a missing person. The respond time with maximum number of staff was 3 minutes and respond time with minimum number of staff was 10 minutes to search internal and external area of the centre. After the search for the missing person, if there is no sighting of the missing person within the maximum of 10 minutes the local Gardai and the next of kin are contacted. The policy will be update to reflect
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<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
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<tr>
<td>There was no procedure outlining the measures to control the risks associated with accidental injury residents, visitors or staff.</td>
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<tr>
<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<td>Policy will be developed outlining the measures to control the risks associated with accidental injury residents, visitors or staff.</td>
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<tr>
<td>There was no procedure outlining the measures to control the risks associated with aggression and violence.</td>
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<tr>
<td><strong>Action Required:</strong></td>
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<tr>
<td>Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.</td>
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<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
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<td>Policy will be developed outlining the measures to control the risks associated with aggression and violence.</td>
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<td><strong>The Registered Provider is failing to comply with a regulatory requirement in</strong></td>
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the following respect:
There was no procedure outlining the measures to control the risks associated with self-harm.

**Action Required:**
Under Regulation 26(1)(c)(v) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

**Please state the actions you have taken or are planning to take:**
Policy will be developed outlining the measures to control the risks associated with self-harm.

---

**Proposed Timescale:** 28/02/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The emergency procedure required improvement. It stated that portable heaters would be available in the event of a loss of heating however, the location of the heaters was not detailed. The procedure referred to a generator and the centre did not have a generator on site.

The emergency box was not stored in the room detailed in the procedure. There was no system for checking if the items contained in the box were present and working. The inspector found that the torches were not working.

**Action Required:**
Under Regulation 26(2) you are required to: Ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

**Please state the actions you have taken or are planning to take:**
Emergency procedure will be updated to outline the location of the portable heaters and generator.
The emergency box has been relocated and items will be checked with the checks carried out on the emergency trolley.

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**Proposed Timescale:** 18/12/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no written procedure outlining the arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Action Required:**
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

**Please state the actions you have taken or are planning to take:**
A written procedure outlining the arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents will be put in place.

**Proposed Timescale:** 31/01/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The provision of hand sanitising gel required improvement as the location of dispensers was not easily accessible to all resident bedrooms.

An audit carried out by the person in charge showed that there was no documented system for responding to an outbreak of infection. There was no evidence this had been addressed.

**Action Required:**
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

**Please state the actions you have taken or are planning to take:**
Three additional hand sanitising gel units have been fitted on the first floor and one additional unit on the ground floor.
A system for documenting and responding to an outbreak of infection will be developed

**Proposed Timescale:** 31/01/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Immediate Action Plan:
The internal fire doors in the centre did not provide adequate protection in the event of
a fire. Some fire doors did not close when the fire alarm was activated. Some fire doors did not contain intumescent strips and others did not contain full intumescent strips. Some sitting room and bedroom doors were being held open with items.

**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:**
A Qualified engineer was hired to discuss and outline work that needed to be carried out on internal fire doors, the work was carried out and the engineer returned to sign off on the work. All internal fire doors are now working and fully compliant.

**Proposed Timescale:** 25/11/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no safe exit from the enclosed garden to the front of the building in the event residents were evacuated in an emergency and could not re-enter the building.

A couch was found blocking a doorway on two consecutive fire drills.

**Action Required:**
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
An exit has been opened to allow evacuation from rear garden.
The chair that was found blocking an exit on two consecutive internal fire drill was removed so it is no longer a risk.

**Proposed Timescale:** 25/11/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The fire alarm was not being tested and the inspector found that not all fire doors were closing when the alarm was activated.

**Action Required:**
Under Regulation 28(1)(c)(iii) you are required to: Make adequate arrangements for
testing fire equipment.

Please state the actions you have taken or are planning to take:
The fire alarm is and has been tested quarterly as per regulations. All fire doors are now working.

Proposed Timescale: 25/11/2014
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in fire prevention.

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:
All staff had received training in fire prevention; however some staff were overdue for retraining at time of inspection. Fire prevention training is scheduled for all staff who were last trained in 2010 and 2011. Training needs are discussed at the monthly management meeting so the training matrix will be reviewed monthly to avoid any staff member not being retrained within the required time frame.

Proposed Timescale: 02/12/2014
Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that all staff had taken part in a fire drill. Fire drills had not taken place between July 2013 and May 2014.

Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Attendance sheets have been added to fire drills and recorded in the training matrix to
ensure all staff are involved in fire drills. Findings from fire drills are always discussed at staff meeting and all staff made aware of outcomes, this is documented in the minutes of our staff meetings and maintained in the monthly management meeting log.

In the last eight months the centre has increased the frequency of fire drill considerably; scheduled weekly fire drills commenced on the 02/12/14 and will continue weekly for a number of weeks until all staff have been involved in at least one fire drill. The addition of attendance sheets will ensure documented evidence that all staff are involved in the fire drills.

**Proposed Timescale:** 25/11/2014

### 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 no measures in place to ensure medications which needed to be discarded after being open for a specific period of time were discarded. It was not clear if a medication in use was being used passed the use by day.

Written guidelines outlining the administration of medications to be used in the event of a specific medical emergency were not adequate as they did not clearly outline the response to be taken.

**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:**
A sticker system is now in place to record the date medication is opened and the use by date (period after opened). The policy will be updated to reflect these changes. Policy will also be update to include the guidelines for administration of medications in the event of specific medical emergency and also medication kardex will be update to reflect the interval ,frequency and maximum dose in 24 hours in consultation with residents general practitioner.

A written protocol will be developed after discussion with the multi disciplinary team for each resident who is on specific emergency medication. The protocol will explain the circumstances that specific emergency medication should be administered, maximum dose in 24 hours, frequency, and the possible side effect of specific emergency medication. Same will be attached to the residents care plan and with the medication kardex for the review of all nurses prior to the administration of medication. Same will
be reviewed every three months or as needed.

**Proposed Timescale:** 07/12/2014

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<td><strong>Theme:</strong></td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Access to physiotherapy was identified as a required need for a resident and had not been facilitated as outlined in the care plan.

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

**Please state the actions you have taken or are planning to take:**
Resident care plan has been updated to identify the frequency of physiotherapy.

**Proposed Timescale:** 17/11/2014

<table>
<thead>
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<th>Outcome 12: Safe and Suitable Premises</th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td>Effective care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Improvements were required to ensure the premises and equipment met the requirements of the regulations and assessed needs of residents.

**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:**
New call bells have been ordered to replace the broken call bells.

The saddle board on entry to one of the sitting rooms will be replaced.

Lockable storage will be made available to all residents.

Request to keep one multi occupancy room has been sent on separately, this three bed
The room is laid out as three individual units separated with partition walls and curtains each having its own vanity/sink unit, a communal hall entrance and a shared full en-suite.

**Proposed Timescale:** 12/12/2014

**Outcome 13: Complaints procedures**

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The complaints procedure inappropriately categorised abuse, exploitation, assault or neglect as complaints which should be addressed to the Authority, the HSE or the Gardaí.

The contact details of the person who complainants could contact if they wished to appeal the findings was not included in the condensed version of the complaints procedure which was on display in the centre.

**Action Required:**
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

**Please state the actions you have taken or are planning to take:**
The complaints procedure inappropriately categorised abuse, exploitation, assault or neglect as complaints which should be addressed to the Authority, the HSE or the Gardaí, our complaints procedure will be amended to address this.

The contact details of the person who complainants can contact if they wish to appeal the findings of a complaint are now added to the summary of complaints policy which is on displayed at centre.

**Proposed Timescale:** 29/12/2014

**Theme:**
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The inspector found details of a complaint documented in the centre’s log for recording near miss incidents. There was no evidence this complaint had been addressed.

**Action Required:**
Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.
Please state the actions you have taken or are planning to take:
The complaint referred has been transferred into the complaints log and the complaints procedure followed.

**Proposed Timescale:** 09/12/2014  
**Theme:**  
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
There was no independent person specified with a monitoring role to ensure that complaints were responded to and records maintained.

**Action Required:**  
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:  
The centre has a complaints team in place and depending on the nature of the complaint the team will decide who is best to lead and deal with the complaint. The Centre’s general manager has been removed from the complaints team so will now take the new role of complaints officer to oversee all complaints in the centre this role will involve the review of all paperwork and ensure that complaints have been responded to and all records maintained. The complaints policy will be updated to reflect these changes.

**Proposed Timescale:** 31/12/2014  
**Theme:**  
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:  
The procedure did not outline who would be responsible for investigating complaints if a complaint was received in relation to one of the centre's named investigative team.

**Action Required:**  
Under Regulation 34(1)(c) you are required to: Nominate a person who is not involved in the matter of the subject of the complaint to deal with complaints.

**Please state the actions you have taken or are planning to take:**  
The policy will be updated to reflect the required changes.

**Proposed Timescale:** 31/12/2014
## 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:**
Residents' end of life care wishes had not been assessed. There was no assessment of residents' end of life wishes in regard to care and comfort which would address residents' physical, emotional, social, psychological and spiritual needs.

**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:**
End of life assessment commenced in September 14 and is due for completion mid December 14. The above will be assessed for all residents during this time.

**Proposed Timescale:** 12/12/2014

## Outcome 15: Food and Nutrition

### Theme:
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Documentation pertaining to modified consistency diets required improvement as different terminology was in use in the centre and in some care plans, which could increase the risk of residents receiving diets inconsistent with their assessed needs.

**Action Required:**
Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

**Please state the actions you have taken or are planning to take:**
A full review of all residents nutritional care plans has been carried out to correct any inconsistencies between care plans and diet list in the kitchen.

**Proposed Timescale:** 17/11/2014
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The menu required some amendment to ensure that residents were aware of the choice of meals. The display of the weekly menu rather than a daily menu could be confusing and there was no pictorial menu in place for residents who could not read the menu.

Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

Please state the actions you have taken or are planning to take:
Residents at the centre were asked if they would like a daily menu instead of weekly menus, all residents said they prefer the menu as it is this is documented in all residents nutritional care plans. Our social care worker is going to work with residents that cannot read the existing menus and develop a more user friendly menu for those residents.

Proposed Timescale: 31/03/2015

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:
There was no independent advocacy service available for residents to access.

Action Required:
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

Please state the actions you have taken or are planning to take:
The centre has started looking into available independent advocacy services and will have an independent advocacy service in place early next year.

Proposed Timescale: 31/03/2015

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The language used in some documentation required improvement. For example, bed rails were referred to as cot sides.

Action Required:
Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

Please state the actions you have taken or are planning to take:
All documentation now used the term bed rails.

Proposed Timescale: 17/11/2014
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Bathroom and bedroom doors did not have locks.

Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
All bedroom and bathroom doors will be fitted with locks early next year.

Proposed Timescale: 31/03/2015