

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Cahercalla Community Hospital
Centre ID:	OSV-0000444
Centre address:	Cahercalla Road, Ennis, Clare.
Telephone number:	065 682 4388
Email address:	paulaohalloran@cahercalla.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Cahercalla Community Hospital Limited
Provider Nominee:	Paula O'Halloran
Lead inspector:	Mary Moore
Support inspector(s):	Margaret O'Regan;
Type of inspection	Announced
Number of residents on the date of inspection:	104
Number of vacancies on the date of inspection:	7

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, 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.

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:	To:
10 February 2015 09:45	10 February 2015 18:30
11 February 2015 09:45	11 February 2015 21:00

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

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

Summary of findings from this inspection

This inspection was the seventh inspection of the centre by the Authority. The inspection was facilitated by the nominated provider, the person in charge and staff. Inspectors observed care practices, spoke with staff and residents and reviewed documents pertinent to regulatory requirements. Prior to the inspection residents and relatives/ carers were invited to complete questionnaires on a voluntary basis on their experience of the centre. Twenty-five questionnaires were returned to the Authority, 12 from residents and 13 from relatives/carers. The majority of the feedback received was positive in relation to staff and the quality of the care and services received. However, areas that they believed required improvement were also identified and this information was presented in an informed, fair and

empathetic manner. Of note almost half of the questionnaires were returned post the inspection but the areas identified for improvement would largely concur with the inspection findings and included; inadequate staffing levels, more strategies to maintain mobility and independence including greater access to physiotherapy, greater access to activities, the poor response and approach of some staff to some residents.

Prior to the inspection the Authority received information from concerned person(s) and this information was reviewed on inspection and brought to the attention of the nominated provider and the person in charge at verbal feedback in the context of the inspection findings.

There were 104 residents living in the centre, 90 of them on a long stay basis. Staff had assessed the needs of 54% of the residents as of high to maximum dependency. Inspectors concluded that adequate arrangements were in place to meet the healthcare requirements of residents such as access to GP services and other healthcare professionals; staff spoken with were knowledgeable as to resident's needs and the supports in place to meet them.

Inspectors saw that the provider had invested in a major refurbishment of the premises. While the refurbishment had been completed to a high standard there were ongoing difficulties due to some room sizes and the lack of adequate dining and communal space on some units.

There was evidence of good care and practice and inspectors were satisfied that the provider was committed to operating within the parameters of regulatory requirements. However, this is a large service where residents invariably present with differing needs and challenges. The inspection findings did not support the adequacy of staffing levels to meet the assessed needs of all residents so as to ensure the best possible clinical, safety and quality of life outcomes for residents. The inspection findings did not support the adequate supervision of all staff at all times to ensure the expected standard of care and behaviour was adhered to at all times. There was evidence of review, discussion and feedback of the care and services provided but what was not clear was what learning took place and what impact if any this process had in improving clinical and quality of life outcomes for residents.

Of the eighteen outcomes inspected the provider was judged to be compliant with six, in substantial compliance with two, in moderate non compliance with five and in major non-compliance with five; staffing, residents rights, dignity and consultation, the submission of notifications, safeguarding and safety, and the premises. The findings to support these judgements were discussed at verbal feedback with the nominated provider and the person in charge and are also discussed in the body of this 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 dated November 2014 contained most of the information required by Schedule 1 and it was an accurate reflection of the services and facilities provided by the provider to residents.

It did not however contain;

- the systems in place for consultation with and the participation of residents in the operation of the centre
- the arrangements for the management of the centre in the absence of the person in charge

Judgment:

Substantially 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 and systems and procedures for the ongoing review and monitoring of the quality and safety of care and services provided to residents. However, based on the overall inspection findings inspectors were not satisfied that the management system and the systems of review ensured that that service and care provided was safe, appropriate to residents needs, consistent and effectively monitored.

The person in charge and the provider nominee both worked full-time in the centre. Each unit had a designated clinical nurse manager (CNM) who also rotated on a structured basis to provide management cover at weekends and were on duty up to 20:00hrs. However, the management resources was consolidated and prioritised within the hours of 08:00hrs and 20:00hrs and there was no management resource from 20:00hrs to 08:00hrs in what is a large and complex service. There was evidence to support that this arrangement was not sufficient and required review by the provider.

Each clinical nurse manager undertook audits on their respective area of responsibility; in addition to enhance the transparency of the process they completed audits on units other than their own unit. There was a quality and safety committee that met on a monthly basis and was representative of all grades of staff employed. The board of directors met on a monthly basis and the nominated provider attended these meetings. Examples of audits completed included medication management, care planning and record keeping, health and safety, environmental hygiene, staff appraisals, accidents and incidents; clinical indicators as referenced and advised in Standard 30 were collated on a weekly basis.

However, while there was evidence of review, discussion and feedback what was not clear was what learning took place and what impact if any this process had in improving clinical and quality of life outcomes for residents.

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:

A guide to the centre was available to residents and it contained all of the required information.

The person in charge confirmed that she was responsible for the provision and agreement of contracts for the provision of services with residents and/or their family. This is a large service but the person in charge confirmed that contracts were in place other than in an exceptional circumstance. The inspector reviewed a random sample of contracts across each of the five units; there was no resident in this sample without a contract. There was a lack of consistency in the format of the contracts seen; more recently issued contracts were substantially compliant with regulatory requirements but the majority were not. Deficits identified included;

- it was not at all times clear whether the resident was in receipt of state support schemes or not
- the fee outlined did not reflect the current agreed fee
- it was not clear from some contracts seen what fee was actually charged. For example where it was clear that a resident was in receipt of state support scheme the fee to be charged did not reflect this status
- all contracts seen did not set out all fees charged including the fee for additional services that the resident may choose to avail of.

Judgment:

Non Compliant - Moderate

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge was suitably qualified and experienced. The person in charge was a registered general nurse and midwife; she had established experience in the centre and was in post as person in charge since 2001. The person in charge was employed full-time and was present in the centre Monday to Friday. The person in charge was known to residents and relatives who confirmed that she was available to them if and when necessary. On speaking with, the person in charge was knowledgeable as to the needs of the residents and regulatory requirements. There were processes in place including the multi disciplinary meetings and the quality and safety committee that facilitated the person in charge to be actively engaged in the governance, operational management and administration of the centre on a regular and consistent basis.

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):

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

Findings:

Overall inspectors were satisfied that the records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 were in place and were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval.

There was documentary evidence that the provider was insured against accidents to residents, staff and visitors.

Records as appropriate were securely stored but residents had access to records pertinent to them such as their plan of care.

Policies and procedures were reviewed and current; policies were signed at unit level as read and understood by staff; with the exception of the use of restraint and the protection of vulnerable adults, specific policies reviewed by inspectors were reflected in practice.

Judgment:

Compliant

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 and had adhered to the notification requirements to the Chief Inspector for the absence of the person in charge. Suitable arrangements were in place for the management of the designated centre in the absence of the person in charge. A clinical nurse manager (CNM) was the designated deputy and person participating in the management of the centre (PPIM). The CNM was suitably qualified and experienced and had established experience of assuming the role of person in charge on a routine basis. The CNM was willing to undertake the role and clearly understood the duties and responsibilities this entailed.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Adequate measures were not in place to protect residents from being harmed or suffering abuse particularly where a resident was deemed by staff to lack mental capacity or cognitive ability.

There was a suite of policies in place with a protective component including the management of any alleged, suspected or reported abuse; the management of behaviours that challenged and the use of restraint.

Education on protecting vulnerable adults was facilitated in-house by a CNM who had completed the train the trainer programme; training records indicated that 97 staff had attended education on protection in the twelve months prior to the inspection. There was evidence that the provider did take action, up to and including protective measures in response to allegations of abuse. Staff spoken with confirmed their attendance at training and told inspectors that they had never seen or heard anything untoward but that if they did they would report to their ward manager or the person in charge. This would not however concur with documents submitted to the Authority and further separate records seen on inspection. These records indicated that;

- all staff did not recognise, accept or report alleged abuse when the allegation was made by a resident deemed by them to be "confused" or "unreliable"

- a separate allegation of alleged abuse made by a resident in October 2014 was not investigated at the time it was alleged or subsequently when reviewed by the quality and safety committee. The incident was not notified to the Authority.

There was evidence of good practice in relation to the use of physical restraint but also evidence of poor practice that was not evidence based and compromised resident rights, dignity and choice. Restrictive practices including bedrails, lap-belts and chairs with attached bed-tables were in use. The restraint policy was evidence based, staff had signed as having read and understood the policy; the policy reiterated the right to autonomy and dignity regardless of capacity. A register of restrictive practices was maintained, there were records of two hourly monitoring while restraints were in place, risk balancing tools and restraint care plans. There was further physical and documentary evidence of the review and removal of a restrictive device and the provision of alternatives including a low-low bed and an impact reducing floor mat. However, overall the incidence of restraint was high and on one unit 62% of residents had bedrails in place. Inspectors were concerned to find physical restraint in use as a falls prevention strategy when this is universally agreed to be ineffective and not evidence based. Records seen indicated that a restraint was in use without the consent and against the expressed wishes of a resident, a resident that could mobilise safely with the assistance of a mobility aid and staff supervision as seen by inspectors. It was clearly recorded that the resident did not want to be restrained and had the ability to remove the restraining device. While it was clear that the resident was at high risk of falling and had a history of falls and injury it was not evident what other less restrictive interventions had been put in place including staff supervision or a movement alarm device by day. It was clear that the restraint had a significant negative impact on the quality of life of the resident and the resident had no means of securing staff assistance "unless I see them". The resident had eight recorded falls between October and January 2015; four of these occurred between 20:00hrs and 08:00hrs and none of the eight falls had been witnessed.

Staff had received training in the management of behaviours that challenged; there were behaviour recording charts in use and behaviour management care plans. Some of these records indicated that some staff understood the therapeutic management of such behaviours including attention to diet, fluids, toileting requirements or diversion. However some records indicated that some staff sought to achieve compliance, for example returning a resident to bed when the resident repeatedly got out of bed. As discussed in relation to protection there was a lack of understanding by some staff of the potential lucidity and veracity of statements and the right to protection regardless of the cognitive ability or capacity of residents.

The inspector reviewed the procedures and systems in place for the management of resident's finances including charges levied. The inspector was satisfied that transparent and procedures were in place supported by appropriate record keeping including the operation of individual patient property accounts.

Judgment:
Non Compliant - Major

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:

There was a centre specific health and safety statement signed as reviewed and updated in May 2013.

The risk register was also centre specific and contained assessments for identified risks such as the stairwells, storage, uneven floor surfaces and the consumption of tobacco. The risk register also contained assessments and identified controls for the risks as specified in Article 26(1) (c).

The fire register was well maintained and from it the inspector saw that the emergency lighting, fire detection system and fire fighting equipment were inspected and tested at the prescribed intervals most recently in February 2015, January 2015 and June 2014 respectively. There were in-house procedures for reviewing and monitoring fire safety procedures. Diagrammatic fire evacuation notices and actions to be taken in the event of fire were prominently displayed throughout the building. Escape routes were clearly indicated and unobstructed and final fastenings were linked to the fire detection system. Staff spoken with confirmed their attendance at fire safety training and at simulated fire evacuation drills that were convened on a monthly basis; staff articulated adequate knowledge of the actions to be taken in the event of fire including the evacuation of residents.

Procedures were in place for the prevention and control of infection. 54% of residents were now accommodated in single bedrooms; designated wash-hand basins were provided on circulation routes; environmental hygiene practices were audited weekly; the majority of staff had attended hand hygiene training; a bedpan washer was provided on each unit; staff were knowledgeable as to the use of equipment and maintenance of equipment such as nebulisers; procedures were in place for the management of sharps and blood/ body fluid exposure; records were maintained of the removal of hazardous waste.

Manual handling training was provided in-house by two certified trainers; attendance was monitored by the nominated provider. The appropriate equipment was in place and there was documentary evidence that it was serviced in line with legislative requirements.

There was a plan for responding to emergencies including the evacuation and alternative placement of residents. A generator was in place.

Resident smoking was accommodated. There was a designated smoking area on the ground floor, it was mechanically and naturally ventilated, connected to the fire detection system, fire fighting equipment was in place as was a call bell and a fire retardant apron. There was a generic risk assessment in the risk register, however staff spoken with confirmed that each resident's capacity to smoke safely was not individually assessed and identified risk controls as seen in a care plan such as staff accompaniment were not implemented.

There were numerous open stairwells between floors and their risk was identified on previous inspections. Following their risk assessment an alarm system was introduced by the provider for use with residents assessed as at risk. The inspector observed however and staff spoken with confirmed that all approaches to all stairwells in the Garden Wing were not adequately controlled.

Notifications received by the Authority between the 8 July 2014 and 17 January 2015 indicated that ten residents sustained falls and injuries that required notification; 50% of these residents sustained a significant fracture; all of these falls were recorded as unsupervised. Based on this information inspectors reviewed the prevention and management of falls in the centre.

There was a policy in place for the prevention and management of falls and evidence in practice of falls prevention strategies including a validated risk assessment, a falls diary, low-low beds, impact reducing floor mats, non-slip socks, hip protectors and movement alarm devices and sensors. A process was in place for the individual and collective review of accidents and incidents including falls. Accident and incident forms were completed by frontline staff, these were then reviewed by the person in charge and a further review was undertaken by the inter-disciplinary quality and safety committee. This culminated in a report detailing the analysis of falls a sample of which was reviewed by inspectors. This included an analysis of time, location, injury received and whether a fall was witnessed or not.

What was not clear was what learning if any took place and what impact if any this process had on reducing either the incidence of falls or the type and severity of injuries sustained as a result of falls: this gap and recommendations had previously been identified to the provider by inspectors in October 2011. It was clear from the analysis of falls seen by inspectors that patterns emerged predominately in relation to the location of falls (both unit and bedroom), the time of falls (20:00hrs to 08:00hrs), and the unwitnessed nature of the majority of falls (up to 100%) but these did not appear to have been analysed further. Staff reported that the sensor alarms were of assistance in alerting staff but accepted that if their response time was delayed by perhaps attending to another resident the resident at risk may have already fallen; this was validated by the fall records seen by inspectors; further records seen indicated that the sensor alarms did not at all times activate. There was an emphasis in falls prevention plans on more "mechanical" interventions such as alarms as opposed to a more holistic review of both intrinsic and extrinsic factors such as medication review, continence, physiotherapy review and input and staffing levels.

Judgment:

Non Compliant - Moderate

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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:
Medication management practice was guided by written operational policies and procedures, staff training, and ongoing assessment of staff competency.

Medication administration practice as observed by the inspector was in line with regulatory body guidance. Written instructions were in place for the administration of medication in an altered format (crushed) and for medications with specific administration requirements so as to maximise their therapeutic effectiveness. Discontinued medications were clearly signed and dated as such.

The inspector with staff reviewed the storage and management of medications requiring stricter controls and these were in line with the relevant legislative requirements.

There was documentary evidence of the review of residents prescribed medications as required and routinely on a three monthly basis.

Medication management practice was the subject of regular audit.

However, medication prescription charts were routinely transcribed by nursing staff and while transcribed charts were the subject of audit inspectors were not satisfied that the audit process was sufficiently robust. Audit reports seen attested solely to the signing of transcribed records by the transcribing nurse rather than the accuracy of the transcribed prescription as it was intended and prescribed by the original prescriber such as correct drug type, dosage, time etc.

There was only one nurse on each floor and while the reported incidence of errors was low, the impact of other demands on nursing staff while undertaking medication administration such as disturbance had not been risk assessed so as to identify existing and any other controls that may be required. This was discussed by way of recommendation at verbal feedback.

Judgment:
Non Compliant - Moderate

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:

There were policies and procedures in place for the identification, management and recording of all adverse accidents and incidents occurring in the centre. The management of and learning from accidents and incidents is discussed in outcome eight; health and safety.

Records reviewed on inspection indicated that all required notifications had not been submitted as required to the Chief Inspector including a recurring pattern of alleged theft, an allegation of abuse and the unexplained absence of a resident from the centre.

Judgment:

Non Compliant - Major

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:

Overall the inspection findings concluded that arrangements were in place to meet residents assessed healthcare needs as set out in their individual plans of care. The provider was requested to review falls prevention and management strategies and the use of physical restraint and these are discussed respectively in outcomes seven and eight.

In so far as was reasonably practicable residents were facilitated to retain the services of their preferred General Practitioner (GP) and approximately ten GP's attended the centre. Residents were referred to other healthcare professionals including occupational

therapy, speech and language therapy, dietetics, mental health services, physiotherapy and optical review; a mobile dental service was available as and when required.

Staff spoken with were knowledgeable as to residents care needs and the plan in place to support those needs.

The nursing plans of care seen by inspectors were based on the assessment and reassessment of residents needs and supported by a suite of validated assessment tools. Plans of care for identified problems were in place such as wound prevention and management, fall prevention and management and nutrition; the plans were personalised and specific to the resident. Recommendations from other healthcare professionals were incorporated into the nursing plan of care. Each plan was reviewed at a minimum four monthly or more frequently as required; this was evidenced on inspection. Staff described the process for consultation with and the participation of the resident and/or relative in the care plan and this concurred with the feedback received from residents and relatives.

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):

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

Findings:

The design and layout of elements of the centre did not meet regulatory requirements and did not meet the individual and collective needs of residents on a daily basis.

The core structure of the premises served as a convent for a religious order; extensions were added over the years most recently in 2008. A major refurbishment of the premises was undertaken by the provider and completed in 2013. The refurbishment was completed to a high standard and substantially addressed the issue of multi-occupancy bedrooms but did not however address the lack of sufficient communal, dining and recreational space identified at the time of the very first inspection of the centre in May 2010.

The premises is divided into five units over three floors; Ground floor and Ground Floor Garden Wing, St Josephs and First Floor Garden Wing and the Sacred Heart Unit. Thirty nine residents can be accommodated on the ground floor, fifty two on the first floor and 20 on the top floor.

Insufficient communal and dining space was provided on both the Garden Wing ground floor and first floor. The available space served as dining, recreational and communal space and did not provide sufficient space for any purpose for the number of residents accommodated on each floor.

Combined dining, recreational and communal space was provided on St Josephs and Sacred Heart Unit. While not ideal, staff were seen to maximise residents' use of the space and the available space did accommodate the majority of residents. Inspectors observed however, that invariably the space was cramped and not conducive to providing a welcoming and relaxing communal area.

Combined dining and communal space was provided for the ground floor in a single room located off the unit. This room was seen to be used only for the main midday meal; staff spoken with confirmed that it was not used in the evening and it was not observed to be used as communal space by residents.

Private accommodation for residents is now provided in 60 single bedrooms and 24 twin bedrooms. There is only one remaining three bed multi-occupancy room on the Garden Wing First Floor. The room was convenient to the nurse's station, was spacious, bright and adjacent to a bathroom. However, on both days of inspection, given the lack of suitable communal space, this room which is each of the three resident's private accommodation was used to provide group recreational activities.

Inspectors identified two twin bedded rooms that were of insufficient size to accommodate two residents. It was not possible to fully open one bedroom door due to the position of one bed, beds were placed against the walls and against radiators, it was difficult to access the wardrobe and there was insufficient space to provide a chair for each resident.

Inspectors noted that some flooring was of a very smooth finish with a high glare and this requires risk assessment and review to ensure its suitability and safety.

En suite sanitary facilities were provided in 53 of the available 85 bedrooms. Additional sanitary facilities were provided on each floor some of which were designed and laid out to provide universal access.

The premises was clean, in good decorative order given the recent refurbishment, adequately heated lighted and ventilated.

Two lifts were provided between floors.

Residents were seen to be provided with the equipment necessary for their comfort and wellbeing. Records were seen of the regular inspection, testing and maintenance of equipment. An anomaly was the testing and maintenance of fall alert sensors and this is

discussed in outcome 8.

Following the completion of the refurbishment works a garden with secured perimeter was provided on the ground floor.

There was some storage of equipment such as hoists on lobbies but this was risk assessed and clearly delineated.

The catering facility was monitored by the relevant Environmental Health Officer and inspection reports and records of actions taken by the provider in response to them were available for inspection.

Judgment:

Non Compliant - Major

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 in place for the receipt and management of complaints including their oversight and the process of appeal; the complaints procedure was clear and prominently displayed. Residents and relatives surveyed said that staff were open to receiving suggestions or expressions of dissatisfaction (described as minor) and that matters had been resolved to their satisfaction. A record was maintained of complaints and the records seen by inspectors indicated that there was a low level of complaints received and the matters complained of were on the whole minor.

However, one record seen related to a reported alleged breach in the expected standard of staff behaviour; there were three corroborating accounts of the reported behaviour. There was documentary evidence of some action taken but no evidence to support learning and improvement or what measures were put in place to prevent reoccurrence such as the monitoring and supervision of staff behaviours which was the essence of the complaint and the recommended action.

Judgment:

Non Compliant - Moderate

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 arrangements in place including policies and procedures, staff training, care planning and physical facilities to ensure that each resident was supported to achieve a comfortable and dignified death.

Five single en-suite bedrooms were allocated to the provision of palliative and end of life care; there were dedicated facilities including overnight facilities available to families.

Staff spoken with said and records seen supported that staff had received a range of education and training on end of life care the scope of which addressed both the physical and psychosocial aspects of care such as the management of syringe drivers and "what matters to me". Care as appropriate was guided and supported by the specialist palliative care team.

Staff reported and there was documentary evidence that all religious beliefs and practices were facilitated and that the provider took extra measures to facilitate this in line with individual beliefs.

End of life care requirements and wishes and the supports in place to meet these were explicitly set out in an end of life care plan. Staff spoken with articulated knowledge, sensitivity and compassion; relatives spoken with confirmed this.

There was evidence to support advanced planning for unexpected deaths. Staff had undertaken basic life support training, there was an AED (defibrillator) available on site and formal discussions with residents on decisions to attempt or not attempt resuscitation. A system was in place for the communication of such decisions to staff to ensure that the decision was respected.

Arrangements were in place for the removal of the deceased; families had access to both the mortuary and chapel on site if requested. Respectful proprietary bags were available for the return of personal belongings. Staff reported that a memorial mass was held annually for deceased residents.

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:

Based on these inspection findings inspectors were satisfied that arrangements were in place to ensure that residents nutritional requirements and choices were met.

Residents body weights were monitored monthly or more frequently if indicated and staff were provided with the required equipment including a hoist based weighing scales for dependent residents. A validated nutritional risk assessment tool was in use. Where a nutritional or fluid intake risk was identified daily monitoring of dietary and fluid intake was implemented. As appropriate residents were referred and had access to other health care services including occupational therapy, speech and language therapy and dietetics. Recommendations were seen to be incorporated into the nursing plan of care and updated following each review.

A menu was in place and the provider had arranged for an evaluation of its nutritional content; the outcome was satisfactory.

Residents spoken with confirmed that the "food was good" and the feedback received from residents and relatives surveyed was also positive in relation to the choice and quality of the meals provided.

Staff were seen to provide appropriate and adequate assistance to residents and family members were also facilitated to be present at mealtimes if this was their preference.

The lack of adequate dining space is discussed in outcome 12: safe and suitable premises.

Judgment:

Compliant

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 were formal systems in place for consulting with residents. A residents' forum was convened and rotated between each unit to maximise representation, comment cards were readily available and a formal survey of residents' satisfaction was undertaken. Overall based on the records seen by inspectors the feedback received was positive and had been improving incrementally. There was evidence that the feedback influenced change such as the provision of sky sports.

Inspectors noted some less favourable comments with regard to room sizes and this would concur with these inspection findings.

Inspectors were satisfied that there were arrangements in place to facilitate resident's political and religious rights. Residents was registered and facilitated to vote; mass was said daily in the centre and broadcast to each unit; there was evidence that other religious beliefs were respected and accommodated.

While there was substantial evidence of good practice some practice evidenced did not support, respect and maximise residents' rights and dignity.

As discussed in outcome 7 there was evidence of both good and poor restraint practice. The poor practice evidenced did not facilitate each resident to exercise personal autonomy, choice and control nor maximise resident independence and wellbeing.

One resident who was addressed by inspectors in the name as advised by staff reacted negatively to this and asserted that this was not her chosen/preferred name and was not the name she wished to be addressed as. The resident repeated her assertion on the second day of inspection.

There was evidence as reported to inspectors by some residents that residents were not comfortable using their call bell given the negative response of some staff to this; not all staff respected the privacy and dignity of all residents specifically in relation to their personal and private space.

There were explicit communication plans in place where the nature of the problem was identified, the potential consequences and the strategies in place to support effective communication. However, on a practical day to day basis, there was evidence to support that arrangements were not in place to facilitate each resident to communicate freely such as access to a call bell and some residents did not demonstrate a readiness and comfort in articulating their needs to some staff.

The specific details and evidence to support paragraphs 5 to 8 above were discussed in

detail at verbal feedback with the provider nominee and the person in charge.

The nominated provider confirmed that residents did not currently have access to independent advocacy services.

There were no reported restrictions on visiting; residents and relatives confirmed this. While alternative space other than the residents bedroom was made available for visits there was no one designated space for the purpose solely of meeting visitors in private if requested.

There was a dedicated activities co-ordinator and the programme of available activities was augmented further by the contribution of volunteers and other frontline staff. For example volunteers read or chatted with residents, organised a knitting club or assisted residents to access the garden. There was formal weekly pet therapy visits but other residents expressed their enjoyment of the local cat that visited informally on a daily basis. The activities co-ordinator was a licensed Sonas practitioner and undertook individual and group sessions; other staff were seen to facilitate group reminiscence and yoga in addition to their core role and duties. Daily activity participation records were maintained. However, this is a large service where residents present with different needs and challenges and both positive and negative feedback was received from staff, residents and relatives; there was sufficient evidence to support that further resources were required to ensure consistent availability and access to meaningful engagement. Many residents spoken with had no plan as to how they were to spend their day and were not aware of the planned activities.

Judgment:

Non Compliant - Major

***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 no laundry facility on site and all laundry both general and residents personal property was contracted out to an independent laundry provider; some residents and their families choose to avail of the service while others did not. Staff spoken with said that the service was provided every day with the exception of Sunday and adequate supplies of linen were always available. Arrangements were in place to safeguard resident's personal property; items were discreetly identified and staff maintained

records of all items sent to and returned from the laundry.

The person in charge and other staff spoken with confirmed that resident's personal clothing was at times damaged by the laundry process. Staff said and there was documentary evidence that this was monitored by staff and residents were adequately reimbursed and/or the item was replaced. This will require ongoing monitoring by the provider however to ensure that the arrangements in place ensure the safe return rather than replacement of clothing.

Personal secure storage space was available to residents.

Some wardrobes in shared bedrooms were not adequately segregated to allow each resident to readily retain control over their own clothes and other personal possessions.

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):

No actions were required from the previous inspection.

Findings:

The inspection findings did not support that staffing levels and staffing arrangements were sufficient to meet at all times; the assessed needs of the residents, the design and layout of the building and the supervision of staff. 46% of relatives/ carers surveyed believed, based on their observations and experiences that staffing levels were inadequate and were empathetic as to the demands and constraints that this placed on staff. Inspectors observed nursing staff to relocate between units to facilitate rest breaks; effectively an adequate nursing presence was not maintained on each unit at all times by day and possibly by night based on records seen. Staff reported that three health care assistants rotated between four of the five units between 23:00hrs and 08:00hrs giving a poor staffing to resident ratio of one to eighteen or at times one to twenty six if both staff were on one floor.

In this context, of concern to inspectors was the number of falls that were not

witnessed; records seen indicated that this ranged from 68% to 100%. All fall records seen by inspectors indicated that the fall had actually occurred before staff responded to fall alert alarms. Day rooms/ communal rooms were generally observed to be unsupervised; given the lack of communal space some residents spent the day in their bedroom adding to the challenge of adequate supervision; it was of concern to inspectors to find the use of restraint as a falls prevention strategy.

The reporting relationship of all staff employed was not clear. There was a formal process of staff supervision; this was not however extended to all staff and inspectors were not satisfied based on records seen that it was effectively utilised to manage and monitor incidents of alleged poor staff behaviours so as to improve practice and accountability.

Agency staff were not normally utilised but the person in charge and nominated provider confirmed that agency staff had been engaged for a limited period in late 2014 to cover unexpected staffing deficits.

Evidence of their current registration with their regulatory body was not in place for over 80% of nursing staff employed. The person in charge confirmed that this was related to national discussions in relation to the payment of registration fees.

Inspectors reviewed a sample of staff files and found that they were well presented and contained all of the required information.

There were policies and procedures in place for the recruitment and vetting of volunteers; each volunteer was required to sign an explicit agreement setting out their roles and responsibilities.

Records of education and training completed were maintained. Based on the records seen inspectors were satisfied that mandatory training was provided and was within the required timeframes; staff spoken with confirmed their attendance at fire, manual handling and protection training. Some staff had completed training on the management of behaviours that challenged and further training was planned for the 17 February 2015. Further training completed reflected the context of care and included medication management training, end of life care, nutrition and dysphagia, hand hygiene, wound prevention and management and the use of restraint.

Judgment:
Non Compliant - Major

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:

Mary Moore
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 report¹

Centre name:	Cahercalla Community Hospital
Centre ID:	OSV-0000444
Date of inspection:	10/02/2015
Date of response:	12/05/2015

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 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 contained most but not all of the required information.

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.

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 statement of purpose has been amended to include the systems in place for consultation with, and the participation of, residents in the operation of the centre and the arrangements for the management of the centre in the absence of the person in charge.

Proposed Timescale: 20/04/2015

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:

Based on the overall inspection findings inspectors were not satisfied that the management system and the systems of review ensured that that service and care provided was safe, appropriate to residents needs, consistent and effectively monitored.

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:

Systems for collection, audit and review of information are implemented at the centre. The majority of these systems have been very successful and clinical indicators and positive care outcomes in areas such as infection control, nutrition, wound management and end of life care demonstrate the quality of care delivered. Results from audits and feedback are used in the development and improvement of services for the residents. Examples of this include the introduction of pet therapy into the activities programme and the development of a secure resident's garden.

From feedback gained from inspectors it is acknowledged that some further learning can be gained in the area of falls management and in this regard an external independent assessment has commenced and the recommendations will be used to ensure safe delivery of care for residents.

We are committed to ensuring all outcomes from review and auditing systems are used to improve clinical and quality of life outcomes for residents.

Proposed Timescale: 20/04/2015

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

There was a lack of consistency in the format of the contracts seen; more recently issued contracts were substantially compliant with regulatory requirements but the majority were not.

Action Required:

Under Regulation 24(2)(b) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the fees, if any, to be charged for such services.

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

A full review of all contracts already issued to residents has been conducted. Those with contracts which are not compliant have been issued with a contract addendum which clarifies the position with regard to:

- Whether the resident is in receipt of state support or not
- The fee charged including the fee payable by the resident where the resident is in receipt of state support
- Fees for additional services that the resident may choose to avail of.

Proposed Timescale: 20/04/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Some records seen indicated that some staff sought to achieve compliance when managing behaviours that challenged. As discussed in relation to protection there was a lack of understanding by some staff of the potential lucidity and veracity of statements and the right to protection regardless of the cognitive ability or capacity of residents.

Action Required:

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

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

As identified at inspection staff have already received training in the management of behaviours that challenge and evidence of good management of these behaviours was acknowledged by the inspectors.

Further training has been scheduled for all staff in the management of behaviours that

challenge specific to residents who are deemed to have reduced cognitive ability or mental capacity.

This training will commence with training for senior nurse management in April 2015 and will be extended to all care staff to be completed by May 2015.

Proposed Timescale: 30/05/2015

Theme:

Safe care and support

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

There was evidence of poor practice in the use of physical restraint that was not evidence based and compromised resident rights, dignity and choice.

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:

We have adopted the National Policy on the use of Physical Restraint and are committed to promoting a restraint free environment. It is acknowledged in this report that there is good practice in relation to the use of physical restraint in the centre. This includes maintaining a register, monitoring when restraint is in place, risk balance tools and restraint care plans.

At present 18% of residents in the centre are using bedrails for their safety with a further 11% using bedrails at their own request. 4 residents are using other forms of physical restraint. In all instances a full risk assessment has been conducted using risk balance tools and care plans developed which includes regular monitoring when restraint is in use.

A review of all residents using bed rails or chair tables is currently being conducted and alternatives are being explored in all cases.

A full review will be conducted by the Person in Charge of all future occasions when the use of physical restraint is being considered and on all cases of the use of physical restraint on a weekly basis to ensure all instances are evidence based and support the resident's rights, dignity and choice.

Proposed Timescale: 20/04/2015

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Adequate measures were not in place to protect residents from being harmed or suffering abuse particularly where a resident was deemed by staff to lack mental capacity or cognitive ability.

Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

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

Extensive training is provided to all staff who have direct contact with residents in relation to the prevention, detection and reporting of abuse. All allegations of abuse are dealt with seriously, investigated fully and appropriate measures put in place to ensure protection of residents.

Education sessions for all staff in the importance of reporting allegations even when the residents is deemed to lack mental capacity or cognitive ability have been completed.
Completed

Training is being organised for senior nurse management on how to manage allegations of abuse when the resident making the allegation is deemed to have reduced capacity and cognitive ability. The training will cover recording, investigating, assessing and reporting of such cases.

Proposed Timescale: 30/05/2015

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 a generic risk assessment but staff spoken with confirmed that each resident's individual capacity to smoke safely was not risk assessed and identified controls as seen in a care plan such as staff accompaniment were not implemented.

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:

An individual risk assessment has been completed for all residents who smoke to include an assessment of their individual capacity to smoke safely. The controls identified as part of the risk assessment will be implemented.

Proposed Timescale: 20/04/2015

Theme:

Safe care and support

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

All approaches to all stairwells in the Garden Wing were not adequately controlled.

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:

The alarm system in place to control access to stairwells by residents assessed as at risk has been extended to include all approaches to all stairwells in the Garden Wing.

Proposed Timescale: 20/04/2015

Theme:

Safe care and support

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

It was not clear what learning if any took place and what impact if any the process for reviewing falls had on reducing either the incidence of falls or the type and severity of injuries sustained as a result of falls

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:

Following recommendations from the inspectors in October 2011 falls prevention strategies were implemented at the centre. This was acknowledged in a monitoring inspection in October 2012 "The importance of falls management was stressed at the quality and safety committee meetings and measures were introduced to reduce the falls risk, such as low beds, mattresses on floor beside beds, bed alarms and increased supervision. As a result of these interventions, the incidents of falls had decreased by 50% in one month and the overall number of falls resulting in injury had significantly decreased." and December 2013 "Fall prevention measures were implemented for residents assessed at high risk of falling. The inspector noted that following a fall, residents associated assessment and care plans were reviewed to reflect the current status of the resident and updated where applicable with interventions to reduce the possibility of re-occurrence. The inspector also read that a falls diary was maintained for residents and were used to track falls that had occurred and the measures taken after

the fall.”

From feedback gained on this inspection it is acknowledged that some further learning can be gained in the area of falls management. An external independent assessment of falls management at the centre commenced on 23rd March, 2015.

The assessment commenced with a full review of all falls occurring within the 6 month period July to December 2014

A review of all documentation was also carried out including review of:

- Incident forms
- Falls risk assessment tool
- Falls diary
- Falls observation checklist.

A workshop was facilitated by an external consultant on 16th April with Provider, Person in Charge and ward managers in attendance. Extensive discussion took place regarding current practices in place for falls management and included a review of individual cases. The discussions also included a review of techniques consider best practice and a number of alternatives were considered as part of the review.

The following changes in practice were recommended as a result of the review:

- Revise falls risk assessment tool, trial period of 1 month and to re-assess for effectiveness
- All resident assessed as high risk to be reviewed by Physiotherapist who will conduct a more detailed risk assessment and make recommendations for the prevention of falls
- All residents will be formally checked on an hourly basis and this would be documented on a form/checklist.
- Incident report form for reporting falls to be revised to ensure the capture of all data relevant to the fall including contributory factors and preventative actions taken allowing a root cause analysis to be done.
- Falls committee to be established and to meet monthly to discuss falls – Committee will consist of Person in Charge and Ward Managers. GP, Physiotherapist and Pharmacist to be invited to attend meetings.
- Separate analysis of falls to be completed on a monthly basis and formal review of analysis and individual cases to be conducted at Falls committee meeting
- Rates of falls in each ward to be measured using an agreed formula and monthly rates to be monitored by falls committee
- Education to be provided to all nursing and care staff in falls prevention protocols.
- Formal launch of falls awareness campaign for all staff, residents and relatives
- Information leaflets on falls prevention to be provided to residents and relatives and new procedures to be presented to resident’s forum.

The actions necessary to put the above changes in practice in place are to be completed by 11th May when the committee will be meeting again to launch new falls management procedures.

Proposed Timescale: 20/04/2015

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:

Audit reports of transcribed prescriptions attested solely to the signing of transcribed records by the transcribing nurse rather than the accuracy of the transcribed prescription as it was intended and prescribed by the original prescriber.

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:

Incidents in relation to medication administration, including transcribing errors, are reported through the organisation's incident and near miss reporting process. To date no errors in relation to transcribing have been recorded. However in light of the inspectors' observations in relation to transcribing we have revised our Medication Management policy to reflect our change in procedure as follows:

Where a nurse transcribes, the transcription will be checked by a second nurse. It will then be checked again and signed by the prescribing doctor within a 72 hour period.

Proposed Timescale: 20/04/2015

Outcome 10: Notification of Incidents**Theme:**

Safe care and support

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

All required notifications had not been submitted as required to the Chief Inspector.

Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

The provider and person in charge are aware of the incidents which are notifiable to the Authority and have a good history of reporting relevant incidents as recognised by inspectors in a monitoring inspection in December 2013.

A small number of incidents identified during the inspection were not reported to the Authority because they were not classified within the relevant categories for reporting.

Since the inspection the provider and person in charge have commenced reviewing each incident together on a daily basis in order to ensure that all incidents are correctly classified and those which fall under the categories as set out in Regulation 31 are reported to the Authority.

Proposed Timescale: 20/04/2015

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:

Insufficient communal and dining space was provided on both the Garden Wing ground floor and first floor.

Given the lack of suitable communal space, a multi-occupancy bedroom which is each of the three resident's private accommodation was used to provide group recreational activities.

Two twin bedded rooms were of insufficient size to accommodate two residents.

Some flooring was of a very smooth finish with a high glare.

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:

We have shown enormous commitment to creating an environment that is safe for residents and meets their individual and collective needs in a more comfortable way. A €3.5m refurbishment of the premises was completed in 2013 which, as identified in this report, has yielded accommodation of a very high standard.

At this inspection the inspectors identified that the communal and dining space provided in the Garden Wing was insufficient. The inspectors also identified 2 twin bedded rooms which were considered insufficient in size to accommodate 2 residents.

Following a review of the physical environment it is accepted that these 2 rooms and the dining areas in the Garden Wing are not of sufficient size to meet the required standards. This part of the building was completed in early 2008 prior to the introduction of the National Quality Standards for Residential Care Settings for Older People and did not form part of the recent refurbishment project.

These areas were not identified to us as a concern in previous inspections and therefore we did not have a plan in place to address these issues at the time of inspection.

Since the inspection we have agreed to engage our architects in the development of a

plan to address these areas and we anticipate that this work will take at least 6 months to complete including engaging builders, sourcing finance etc. We are putting forward a timeline for the completion of these works as 31st October, 2015.

In the interim we plan to perform an assessment of the 2 rooms prior to each new admission in terms of the medical, physical and social needs of the prospective residents and their safety, privacy and dignity to ensure there are no negative outcomes for the residents as a result of being accommodated in these rooms. With regard to dining space we plan to implement measures such as having two sittings for meals in order to deal with the limited dining space.

The finish on the floors identified by the inspectors as having a high glare was risk assessed as part of our external Health & Safety assessment of the building which took place on 26th March, 2015. It was found that the floor in this area is no different to that of any other polished linoleum floors in the centre which are not, under normal conditions, recognised as a high risk slip hazard. Completed.

Proposed Timescale: 31/10/2015

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

There was documentary evidence of some action taken but no evidence to support learning and improvement or what measures were put in place to prevent reoccurrence.

Action Required:

Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

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

As identified in the inspection a formal procedure is implemented at the centre for the receipt and management of complaints. Residents and relatives surveyed expressed satisfaction with this. A low level of complaints has been received and the matters complained of are mainly minor.

The incident identified during this inspection concerning staff behaviour was dealt with through the organisation's disciplinary process and no further incidents of this behaviour were reported. However we acknowledge it was not clear from the documentation that it had been considered as part of the performance review and will ensure that such an oversight is not repeated.

As agreed in Outcome 18 the performance review process has been expanded to

include reference to incidents of poor staff behaviours identified through systems in place for ongoing review and monitoring of quality and safety of care including complaints and feedback processes and incident reporting.

Proposed Timescale: 20/04/2015

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:

Arrangements were not in place to facilitate each resident to communicate freely such as access to a call bell and staff response to the call bell and some residents did not demonstrate a readiness and comfort in articulating their needs to some staff.

Action Required:

Under Regulation 09(3)(c) you are required to: Ensure that each resident may communicate freely.

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

Due to an oversight on the day of the inspection one resident did not have access to a call bell. The importance of providing all residents with access to a call bell has been re-iterated to all staff. Completed

A system to monitor response times to call bells and alarms has been activated and response times will be reviewed on a daily basis by the person in charge to ensure acceptable response times are consistently achieved. Completed

All care staff will be provided with training in identifying and responding to residents' needs and anxieties in a caring, willing and timely manner.

Proposed Timescale: 30/05/2015

Theme:

Person-centred care and support

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

There was sufficient evidence to support that further resources were required to ensure consistent availability and access to meaningful engagement.

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:

The activities co-ordinator has reviewed the activities programme and has made recommendations to management with regard to the extra resources which are required in order to ensure all residents have access to meaningful engagement. These extra resources have been provided.

Proposed Timescale: 30/04/2015

Theme:

Person-centred care and support

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

Poor restraint practice did not facilitate each resident to exercise personal autonomy, choice and control nor maximise resident independence and wellbeing.

One resident was not addressed by her chosen/preferred name.

Not all staff respected the privacy and dignity of all residents specifically in relation to their personal and private space.

Action Required:

Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

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

We are committed to respecting the privacy and dignity of all our residents and promoting their right to exercise choice and control in order to maximise their independence. All care staff will be provided with training in these areas and future compliance will be monitored by the Person in Charge and will be incorporated into the peer audits of wards by other ward managers.

Proposed Timescale: 30/05/2015

Theme:

Person-centred care and support

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

There was no one designated space for the purpose solely of meeting visitors in private if requested.

Action Required:

Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident's room, if required.

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

Over 50% of the residents are accommodated in single bedrooms where they can receive visitors in private. Where a resident who is accommodated in a shared room requests to meet a visitor in private the conference room will be made available for this purpose.

Proposed Timescale: 20/04/2015

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:

Some wardrobes in shared bedrooms were not adequately segregated to allow each resident to readily retain control over their own clothes and other personal possessions.

Action Required:

Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

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

A full review of the wardrobe space provided in all shared bedrooms has been conducted and where applicable further space has been provided to allow each resident to retain control of their own clothing and personal possessions.

Proposed Timescale: 30/04/2015

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

The inspection findings did not support that staffing levels and staffing arrangements were sufficient to meet at all times; the assessed needs of the residents, the design and layout of the building and the supervision of staff.

Action Required:

Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

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

A full review of staffing levels at the centre was conducted by the registered provider

and person in charge following the inspection. As a result of this review two extra health care assistants have been approved for rostering on each night. This increase in staffing levels was implemented with effect from 11th May, 2015.
A night supervisor, who will be responsible for the management of staff at night has been approved and has been built into the staff roster with effect from the 11th May, 2015.

Proposed Timescale: 11/05/2015

Theme:

Workforce

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

The reporting relationship of all staff employed was not clear. There was a formal process of staff supervision; this was not however extended to all staff and inspectors were not satisfied based on records seen that it was effectively utilised to manage and monitor incidents of alleged poor staff behaviours so as to improve practice and accountability.

Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

The organisational chart which outlines the reporting relationships for all staff employed has been re-communicated to all staff.

The performance review process has been expanded to include reference to incidents of poor staff behaviours identified through systems in place for ongoing review and monitoring of quality and safety of care including complaints and feedback processes and incident reporting.

Proposed Timescale: 20/04/2015