

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Oriel House
Centre ID:	OSV-0000689
Centre address:	St. Davnet's Complex, Rooskey, Monaghan.
Telephone number:	047 816 77
Email address:	margaret.mcnally@hse.ie
Type of centre:	The Health Service Executive
Registered provider:	Health Service Executive
Provider Nominee:	Rose Mooney
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	0

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:
13 April 2015 11:00	13 April 2015 18:00
14 April 2015 10:00	14 April 2015 17:30

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 was the sixth inspection of the centre by the Authority and was completed in response to an application by the provider to renew registration. The provider nominee changed in March 2015. The person in charge has responsibility for two designated centres since February 2014.

The inspector met with residents, relatives/visitors, and staff members. The inspectors observed practices and reviewed documentation such as care plans, medical records, clinical and operational audits, policies and procedures, contracts of care, notifications since the last inspection and staff files. The inspector reviewed all eighteen outcomes in addition to progress with completion of the action plan from

the last inspection of the centre on February 2014 to assess compliance of the centre with the legislation and standards. The inspector found that not all actions plans were satisfactory completed and are repeated in the action plan with this report. The provider advised the Authority of plans to refurbish the centre to include construction of an extension. This action will address major non-compliances as found on inspection in relation to the inadequacy of the design and layout of bedrooms, toilets and showers to meet the privacy, dignity and quality of life needs of residents living in the centre. A suitable area for residents to relocate to during refurbishment is in place. Consultation with residents and their families required some improvement to ensure their consultation needs were fully met. This finding is discussed further in outcome 12.

During the inspection the inspector met with residents, relatives and staff members. Residents were complimentary about the meals provided, choices they had, the staff team who cared for them and the level of support they received. While residents were facilitated to participate in recreational activity provided, this required review to ensure the activities were co-ordinated by suitably trained staff and that activities provided reflected residents' interests and capabilities. Nine pre-inspection questionnaires were returned, five completed by residents in the centre and four by relatives of residents. Comments generally expressed satisfaction with the facilities, services and care provided.

Staffing levels and skill mix did not adequately meet the supervision needs of residents who remained in bed. This finding is discussed in outcome 18.

The inspector found that the external areas of the centre did not ensure residents' safety and protection needs were fully met in that not all risks were adequately assessed with appropriate controls in place to mitigate risks found. This finding is discussed in outcome 8

There was evidence of implementation of effective quality initiatives that demonstrated positive outcomes for residents. For example a falls care bundle. However, monitoring of the quality and safety of care and the quality of life of residents was taking place but required comprehensive analysis to identify areas requiring improvement as identified on inspection.

Inspectors found staff to engage with residents in a dignified and respectful manner and residents spoken to reported they were happy within their home. Failings were identified with twenty nine regulations on this inspection, nineteen of which are the responsibility of the provider and ten of which are the responsibility of the person in charge. Compliance was identified in six of the outcomes and minor improvements were required in Notification of Incidents.

Moderate non - compliance was identified in the following Outcomes:
Outcome 2: Governance and Management
Outcome 5: Documentation to be kept in the centre
Outcome 7: Safeguarding and Safety
Outcome 8: Health and Safety and Risk Management
Outcome 9: Medication Management

Outcome 11: Health Care Needs
Outcome 13: Complaints procedure
Outcome 17: Residents' clothing and property and possessions
Outcome 18: Suitable Staffing

Major non - compliance was identified in five outcomes:

Outcome 16: Safe and Suitable Premises
Outcome 17: Residents' rights, dignity and consultation

The Action Plan at the end of this report identifies improvements that must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland

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):

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

Findings:

There was a written statement of purpose given to the inspector on the days of inspection that described the service and facilities that are provided in the centre dated 20 March 2015. The statement of purpose consists of a statement of the aims, objectives and ethos of the designated centre. It detailed the facilities and services provided for residents and included the information required in relation to the matters listed in schedule 1 of the Regulations.

A copy of the updated statement of purpose was also forwarded to the Authority. The provider was aware of the need to keep the document under no less often than annual review. The statement of purpose provides a clear and accurate reflection of the facilities and services provided and implemented in practice in the centre

Judgment:

Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a clearly defined management structure in place that identified the lines of accountability and authority in the governance and management of the centre. The designated person in charge had responsibility for two designated centres. The centre was managed on a day to day basis by a clinical nurse manager who deputised for and supported the person in charge in her role. The person in charge routinely attended the centre on a weekly basis and spoke with the clinical nurse manager in the centre on a daily basis. However, this attendance was not scheduled or recorded on the duty roster and weekly meetings or telephone discussions between the person in charge and the clinical nurse manager were not minuted. The inspector found evidence that demonstrated that the person in charge with the support of the clinical nurse manager was involved in the governance, operational management and administration of the centre on a consistent basis. The inspector found adequate evidence that ensured residents' healthcare needs were generally met with the exception of one resident who remained in bed on a consistent basis. This finding is discussed further in outcome 11.

The inspector found that there was a system in place for quality monitoring and improvement to ensure that the service provided was safe, appropriate to meet resident needs, consistent and regularly monitored. However, comprehensive analysis of findings is required in a number of areas monitored to ensure improvements where appropriate are initiated as this information was not recorded in an action plan.

Some improvements in the quality and safety of the service and the quality of life for residents in the centre were evidenced. For example implementation of a falls care bundle which had the desired outcome of reducing resident falls by comprehensive risk assessment and risk mitigation. An auditing schedule was established to measure the quality and safety of care and the quality of the residents' experience in the centre in a number of key areas. Discussions by the inspector with residents and relatives during the inspection and their feedback in the Authorities feedback questionnaires were positive in respect of the provision of the facilities and services and care provided.

A robust refurbishment plan was in place to address the major resident accommodation non-compliances found on a number of inspections to address residents' privacy, dignity and quality of life needs. However, residents' needs in relation to their safe and stress-free transition to their new accommodation in St Mary's Hospital was not adequately met on the days of inspection and requires comprehensive assessment and review to ensure residents' needs are met. This finding is discussed further in Outcome 12.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

There was a residents' guide available which was reviewed by the inspector and found to be updated to keep residents informed of any changes. It contained all the information as required by the legislation. The information in this document functioned to assist prospective residents to make a decision regarding choosing a placement and also informed current residents of the services available to them.

Each resident had a written contract of care which outlined the services provided and the fee to be paid for residency by residents as part of the Fair Deal Scheme. Charges for other services available to residents were included. The centre did not charge residents for social activities. All contracts of care reviewed were signed and dated. The inspector observed that many residents signed their own contract of care.

Residents had access to a hairdresser who attended the centre; a price list was displayed to enable residents to make a choice about the service they required.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge of the centre is Margaret McNally. She was appointed in this role in July 2012 having responsibility as person in charge of two designated centres since February 2014. She is a registered general nurse with Bord Altranais agus Cnáimhseachais na hÉireann. She has completed a postgraduate gerontology course, a management course and is a nurse prescriber. She has the required experience in caring for older persons.

Staff were aware of the management arrangements in place.

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 inspector found that records listed in schedule 1, 2 and 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were maintained in a way so as to ensure completeness, accuracy and ease of retrieval.

All written operational policies as required by Schedule 5 of the Regulations were available and up to date with the exception of the policy advising on protection of vulnerable persons which was missing some relevant advisory information.

Details referencing community elder abuse social worker referral, management of an allegation against a senior member of staff and the document was not centre specific for Oriel House as there was reference to another designated centre in it.

The directory of residents was reviewed by the inspector. The deputy person in charge maintained an electronic copy of the information as required. A paper copy of the document was downloaded on a daily basis.

The duty rota did not contain adequate information to determine whether the roster was actually worked as required by Schedule 4, paragraph 9 of the regulations. The document did not reference the periods worked by staff in the centre.

Records of fire drills completed were not available for review on this inspection as required by Schedule 4, paragraph 10 of the regulations.

Judgment:

Non Compliant - Moderate

Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider was aware of her responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during her absence. The person in charge had not been absent from the centre for more than 28 days to date.

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:

The inspector found that doors to the centre were secured and access was controlled by staff. A visitors' book was located inside the door and completion of it was monitored by staff.

The inspector was provided with a copy of a staff training record which confirmed that all staff had completed training in elder abuse prevention, recognition and management. All staff files reviewed on the days of inspection had evidence of completed appropriate vetting procedures. Staff spoken with were knowledgeable with regard to their role and responsibilities in protecting residents and reporting any suspicions or disclosures made to them. A policy document to inform prevention and protection of residents from elder abuse was dated 2015. This policy was reviewed by the inspector and findings supported review of this advisory document was required as outlined in outcome 5. Residents spoken with by the inspector and entries in pre inspection resident questionnaires supported residents' feelings of safety. Residents said they 'were treated with respect' 'staff were kind and were always willing to assist' them. The inspector observed staff - resident interactions on the days of inspection and found that all staff interactions were satisfactory.

A policy document was in place to inform management of behaviour that challenges exhibited by residents and promotion of a positive approach to managing same whilst supporting the resident concerned. Some staff had attended training in managing challenging behaviour and professional management of aggression and violence. Three residents had documented episodes of challenging behaviour. Triggers and de-escalation techniques were identified for each of these residents. One resident remained in bed and the inspector observed in the resident's documentation and was told by staff that this behaviour was linked to an underlying mental health condition. The inspector found that this resident's behaviour negatively impacted on their quality of life as they tended to stay in their bed and were adverse to any physical contact. While staff and the activity co-ordinator attended this resident in their bedroom, the inspector concluded from findings that this resident was at risk of isolation and social deprivation as they did not engage in a meaningful way in the day to day life in the centre. This resident's care plan advised that if behaviour increases in frequency, intensity or duration a referral to psychiatry of older age, GP and behavioural therapy should take place. While the resident was reviewed by their GP, no recent evidence of referral to psychiatry or behavioural therapy was actioned. This finding is discussed further in outcome 11 of this report. Another resident used an isolated unapproved path to access the local town. There was documented evidence that this resident refused to co-operate with staff efforts to ensure their safety needs were met.

A restraint register was maintained which was reviewed by the inspector. Approximately 36% of residents used bedrails, two of whom used lap-belts. This register or residents' documentation reviewed did not reference alternative methods trialed or evidence of reduction in use. There was no change in the level of restraint used from that recorded in September 2014. There was evidence that some residents were using full-length bedrails as enablers which placed limitations on their freedom to access their bed independently. The inspector observed residents had good access to physiotherapy and occupational therapy services however, there was not evidence that input from these services was sought in restraints used by residents. These findings did not reflect best practice in restraint use or national restraint guidelines.

Management of resident finances were reviewed. Residents' monies were lodged into their named account. The inspector found that all procedures involving residents' finances were transparent and residents were able to access their money when they wished. Supporting policy and procedural documentation to inform management of residents' finances was in place. All residents had access to a lockable facility in their bedroom if they wished to retain control over their valuables.

Judgment:

Non Compliant – Moderate

***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 a health and safety statement in place that had been reviewed on 02 February 2015. A risk management policy was available that included information on matters as required by regulation 26(1).

The risk register was reviewed by the inspector. The document demonstrated identification of risks with stated controls for a number of internal and external areas of the centre in addition to learning from accidents/incidents. However the inspector found risks that were not identified and risk assessed in the risk register. These risks included;

- Risk posed to residents and others by vehicular traffic. While a one-way traffic system was in operation, vehicles passed, parked and were engaged in reversing within close proximity of the centre.
- Vehicle parking in one area encroached onto a footpath.
- The perimeter of the site on one side was unprotected and exposed vulnerable persons to risk of fall down a steep incline.
- Residents did not have access to a safe enclosed area
- The surface roadways accessing the site were potholed and uneven in places.
- The pathway from the centre to the church did not provide protection from the weather to pedestrians and was covered by moss and algae around the church. There were no handrails to assist residents with walking along external pathways or around the church.
- There was no external lighting along the pathway to the church or around the church which posed a risk of trip/slip/fall to pedestrians accessing this area during hours of reduced natural light.
- In addition details of the security arrangements and supports was required due to the remoteness of the site and the absence of secure perimeter fencing or otherwise to ensure all measures were taken to protect residents and staff working in the centre. There had been an incident where the Gardai were called by staff in response to unauthorised persons accessing the immediate surrounding grounds of the centre during the night.

Staff demonstrated how the staff team were assessing and managing potential risk to a resident who spent much of each day out of the centre visiting various areas on the larger St Davnett's complex, and shopping in the town. Whilst aiming to promote this resident's independence, the deputy person in charge demonstrated various alert and safety items that were been trialled to ensure this resident's safety needs are met. However, the inspector found that the site and route taken placed this resident at increased risk as it was isolated and not an established pedestrian route. This finding requires comprehensive risk assessment to ensure this resident's safety needs are fully met. A missing person policy was in place and a missing person profile was in place for this resident.

A falls care bundle for older persons was implemented to advise prevention of resident falls in the centre. The initiative was implemented to prevent resident falls by increasing staff awareness, supporting comprehensive risk assessment and creation of a positive

environment for residents at risk. The inspector was advised that the initiative was introduced in September 2014 with only six incidents from introduction to the time of this inspection, none of which resulted in serious injury. Safe moving and handling training was documented as completed by all staff. An overhead hoist was fitted in one bedroom.

There were two residents identified in the risk register as being at increased risk as they engaged in smoking. The location of the smoking area was the subject of an action plan from the last inspection in February 2014. The inspector found on this inspection that the area had been refurbished to include an extractor fan, a fire extinguisher, a fire blanket and a smoking apron. An emergency call-bell was also available in this room. The door to the room was fitted with a glass panel to facilitate increased supervision of the area by staff.

Fire safety arrangements were reviewed by the inspector with follow-up of actions identified for completion in this area during the last inspection in February 2014. The inspector found that staff were aware of the procedures to follow in the event of the fire alarm sounding. Nearest exits were clearly stated and fire action signs were displayed at regular intervals throughout the building to guide staff and residents in an emergency. The inspector observed that horizontal evacuation procedures were in place supported by compartment configuration of the building throughout. Staff training records confirmed attendance of all staff at annual fire training and participation in fire drill simulation. While there was evidence that staff had completed fire drills in the training records, there was no record maintained of the fire drills completed including evidence that fire drills were simulated to account for day and night-time conditions including staffing levels to ensure adequacy to execute evacuation if necessary. Personal emergency evacuation plans were developed for each resident which detailed their equipment and staff resource needs to evacuate safely. Fire alert and fire fighting equipment was checked and serviced regularly as required. A checking schedule of fire preventative and safety procedures was routinely completed and documented. The inspector observed that the fire exit door in the residents' sitting area had a curtain fitted which could be drawn closed over it. While a key was in a break-glass unit adjacent to this door, it was locked on the days of inspection. These findings were not risk assessed to ensure that they did not hinder emergency exit if required.

The clinical room door which accommodated items which were to be secured safely had a key-code lock fitted and an unlocked cupboard in the visitors' room which contained creams and liquids on the last inspection was observed to be free of these items. The sluice area was reviewed on this inspection to ensure clean items stored in this area on the last inspection in the absence of a suitable cleaning room on the first floor had ceased. The inspector found that this practice had ceased on this inspection. However, a bedpan decontamination unit was fitted on a wooden base. Paint and parts of the surface of the wood were missing and as such it could not be adequately cleaned. The inspector observed that wet equipment taken from the bedpan decontamination unit were placed on wooden shelves. A commode storage room was available for commodes ready for use, surfaces of which were observed to be clean.

During the last inspection in February 2014 linen trolleys containing items of clothing for laundering were being stored on the corridor and broken parts of wheel chairs and other

items were being stored behind the laundry facilities in the laundry room. The inspector reviewed the actions taken to address these findings on this inspection. The laundry room was found to be clear of inappropriate items. Alternative arrangements were found to be in place to ensure linen trolleys were not stored on corridors. Procedures for maintenance of equipment established and ensured any equipment requiring repair was either removed or repaired on-site. Hand hygiene facilities were provided with hand gel stations located throughout the centre. Staff completed training in hand hygiene and standard precautions annually. The centre was visibly clean and free of malodour. While waste was appropriately segregated, tagged and transported, bulk storage bins were located in the pathway of a fire exit, were observed to be overflowing and were not securely stored in an area that prevented unauthorised access.

Judgment:

Non Compliant - Moderate

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

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

Findings:

The inspector carried out a review of a sample of medication prescription and administration records belonging to residents in the centre and attended a medication round in the centre. Prescribing documentation was not adequately completed by residents' GPs (General Practitioner) on the last inspection in February 2014 and was the subject of an action plan. The inspector found that discontinued medications were signed and dated by the residents' GP and maximum doses of 'as required' (PRN) medications were stated on this inspection. A medication management policy informed medication management practices.

Staff nurses had completed medication management refresher training on the days of inspection as referenced on staff training records. Residents who were allergic to individual medications had the medication concerned clearly stated and highlighted on their medication prescription sheets. The inspector observed that residents' medications were stored in a secure press in the clinical room which was also secured. Medications requiring additional security, including balance checks of same in line with misuse of drugs legislation were completed. The inspector attended a medication administration round and found that all practices during same were in line with professional standards.

While medication audits were completed, this was done by staff in the centre and not by the pharmacist in line with obligations as described by the Pharmaceutical Society of Ireland. The pharmacist was available to advise staff as required but did not regularly

attend the centre and was therefore not available to residents. This finding was not in line with regulation 29.

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:

A record of all incidents that occurred in the centre was maintained. All notifications any serious incidents where residents sustained an injury were forwarded to the Authority as required by the legislation.

Quarterly notifications were forwarded however the notification on restraint use did not include use of lap-belts.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The inspector found that all residents' needs were identified in a care plan. Interventions to inform care were comprehensive in the sample of residents' documentation reviewed. There was evidence that residents had risk assessments completed to identify their needs in relation to level of dependency, moving and handling, falls and risk of pressure related skin damage. Daily progress documentation was completed and was generally

linked to care plans. There was evidence that residents and/or their relatives were involved in care plan reviews.

There was evidence to support the requirements for residents' temporary absence or discharge was met.

A resident who experienced an increase in episodes of challenging behaviour was not referred to psychiatry or behavioural therapy as outlined in their plan of care.

While some residents' activity needs were met, some residents such as a resident who remained in bed did not have his /her needs met. There were few activities for residents with a diagnosis of dementia. The requirement for staff training in this area and to coordinate activities is discussed in outcomes 16 and 18

There were also opportunities for some residents to participate in activities outside the centre that were meaningful and purposeful to them and that reflected their interests and capacities. For example, one resident enjoyed using the garden tunnel to grow flowers; another resident enjoyed sweeping the tarmac around the centre. The inspector also met with a resident who left the centre most days to independently walk, visit a relative in the local town and to do shopping. Staff demonstrated where they were trialling a variety of alert systems to ensure her/his safety needs were met, whilst aiming to promote her/his independence while outside the centre. The inspector saw that in the main there were suitable assisted devices available to residents to enable their mobility and independence, with the exception of toilet seat raisers placed over toilet bowls in some resident facilities which posed a risk of fall to residents due to their instability and in the absence of appropriately fitted grab rails. Call bells were observed to be answered promptly by staff.

Judgment:

Non Compliant - Moderate

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 inspector found that the design and layout of the bedroom accommodation and an en-suite in a five bedded room did not meet its stated purpose. This finding has been identified in previous inspections of the centre. The inspector was advised by the

provider nominee that plans are at an advanced stage to close the centre on completion of refurbishment of another designated centre. Residents will be transferred to allow for the proposed construction of a new extension and refurbishment of the existing building to address the non compliances in respect of premises and residents' privacy and dignity needs.

Residents' bedroom accommodation consists of 4 four-bedded rooms, 1 five-bedded room and two twin bedrooms. The size and layout of the bedroom accommodation does not meet the needs of residents in terms of their privacy and dignity. For example, the five bedded bedroom has en-suite cubicle style shower and toilet facilities. While there were showering facilities, there was no bath in order to give residents a choice of bathing facilities.

A single bedroom used for residents at end of life had panel windows in the wall between this room and the visitors' room and in the wall between this room and the main corridor. While fitted with screens, this finding does not ensure the privacy and dignity needs of residents using this room. This is further discussed further in outcome 16.

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:

The complaints procedure was prominently displayed. A complaints log was maintained in the centre and there were arrangements for complaints to be followed through to satisfactory resolution. Verbal feedback from residents or resident's representatives was welcomed and arrangements were in place for recording same in line with regulatory requirements. The inspector observed that while complaints were recorded and there was evidence of action taken following investigation, all correspondence and details of the investigation were not filed together. Therefore, correspondence sent to one complainant as an outcome of investigation was not available for review on this inspection. A record of complainants' satisfaction with the outcome of investigation of complaints was not consistently documented.

The inspector observed that there was evidence of learning with concomitant service improvements following investigation of complaints. Staff were encouraged to take ownership of complaints made and to be involved in action plans. Some residents spoken with were aware of the process and mainly identified the deputy person in charge as the person whom they would communicate with if they had any issue of

dissatisfaction. Residents spoken with told the inspector they did not have cause to complain to date.

There was an advocacy service available if required by residents and a process was in place for auditing the complaint procedure.

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 no residents in receipt of end of life care on the days of this inspection. A review of residents' care plans evidenced that their end of life wishes were discussed and documented. Members of the local religious congregation provided pastoral and spiritual support to residents who were at the end stage of their lives in addition to clergy from the various religious faiths. The centre has a spacious single bedroom facility with a ceiling host fitted, designated for residents in receipt of end of life care. However, while screened, panel windows located in the wall of this room and the visitors' room and the main corridor did not ensure the privacy and dignity needs of residents using this facility were met. This finding is discussed in outcome 16.

The centre provides accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time. Palliative care services were available to residents to support their symptom management. Staff had completed training on end of life care and management of pain, including use of syringe drivers

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was satisfactory evidence that residents were provided with adequate fluid and dietary intake to meet their needs. Residents were offered a nutritious and varied diet that provided them with choice of a hot dish at each mealtime. The inspector observed residents at mealtime and found that those who required assistance received same in a dignified and discrete way by one of members of staff in the dining room. Many residents used mealtimes as a social occasion and chatted with others at their table. The menu was clearly displayed. Food is cooked in a central kitchen on the complex in St Davnett's Hospital and transported in a heated trolley unit to the centre's kitchen. Food was plated in the dining room in front of residents who advised on the portion size and dish they wanted. The centre's kitchen was fully equipped and was stocked with snacks including fresh sandwiches to meet residents' needs. Residents had a choice of clothes protector or napkin.

There was a policy document available to support staff in all aspects of nutritional and hydration care including percutaneous endoscopic gastrostomy (PEG) feeding and subcutaneous fluid administration procedures. Residents' weights were monitored and those identified as at risk had evidence of monitoring and review by dietetic services. Care plans were in place to inform care of residents with nutrition and hydration needs which were satisfactorily linked to monitoring and treatment plans and were evaluated in daily progress notes.

The dining room was spacious. Residents spoken with told the inspectors that they enjoyed the food provided in the centre. Staff training was in place to inform staff on use of the nutrition assessment tool in assessing and monitoring procedures, food fortification and fluid thickening procedures used.

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):

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

Findings:

The inspector was satisfied that residents were encouraged to make choices about how they lived their lives in a way that reflected their individual preferences and diverse needs. However, one resident who remained in bed did not have a follow-up review by specialist psychological/psychiatric services as advised in her/his care documentation to ensure their quality of life was not negatively impacted upon in the absence of adequate assessment and treatment of their mental health needs. This finding is discussed in outcome 11. There was a residents' meetings forum which was minuted and convened approximately every four months. The minutes were reviewed by the inspector and the last meeting was held on 09 April 2015.

While residents were generally informed of plans for refurbishment of their home, the inspector did not find adequate evidence to confirm that a comprehensive consultative process was in place to ensure residents and their families were fully informed and involved in all aspects of the project. This finding requires urgent review as residents are required to move out of their home to an unfamiliar centre in an unfamiliar town for some residents who have lived in Oriel House for a number of decades.

Records were available that recorded participation in activities by residents but did not record adequate information to conclude the activity they participated in adequately met their interests and capabilities.

There was a communication policy in use to inform communication strategies especially with residents who had illnesses and medical conditions that resulted in them having communication deficits. The Inspector also observed that residents had a variety of local and national newspapers available to them and some were observed reading them. The centre also had a mobile phone which residents could use if they wished to speak to relatives in private. Residents' confirmed that they had regular visitors and could choose where they would like to meet them. There was a residents' communication board where items of interest to the residents were displayed.

The layout and design of residents' bedroom accommodation did not ensure their privacy and dignity needs were met. There are four multi-occupancy bedrooms accommodating 4-5 residents. The layout of these rooms is clinical in style and privacy screen curtains are used between beds. An en-suite showering and toilet facility did not meet its stated purpose as it was of a cubicle design. Each resident had a wardrobe and a locker which was limited in size and limited personal possessions that could be stored by residents. Residents did not have adequate shelving and space to display personal possessions. One resident used a window sill and many residents used the wardrobe surface or the wall surface behind their beds to display photographs.

One single room used for end of life care had window panels in the walls between this room and the designated visitors' room and the main corridor. Although screening was fitted, the location of these window panels did not ensure residents' privacy and dignity needs could be adequately met in this area.

A closed circuit television receiving unit was located in the visitors' room. While staff monitored this unit intermittently, it was inappropriately located. A policy document was available which informed use of this security system which was located on external areas of the centre only.

Clergy from different faiths visited the centre and major feast days were celebrated with a service or mass. There are two churches on the site, one of which is boarded up. Mass is celebrated each week in the other church and although in close proximity to the centre, not many residents attended. Mass was celebrated 3-4 times each year in the centre. There were varied responses from residents in respect of access to a Mass service and this finding needs to be reviewed to ensure that each residents' religious needs are met. There was an absence of evidence in residents' documentation reviewed regarding assessment to ensure their wishes were addressed regarding practising their religious beliefs. Local parish bulletins and newsletters are distributed weekly to residents.

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):

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

Findings:

Each resident had a wardrobe and a locker which was limited in size and limited personal possessions that could be stored by residents. Residents did not have adequate shelving and space to display personal possessions.

The centre had facilities for laundering residents' personal clothing. Sheets and towels were laundered by an external service. The inspector observed residents' clothing to be clean and in good condition. Residents and relatives expressed their satisfaction with this service in the Authorities pre-inspection feedback questionnaires. Residents spoken with on the days of inspection told the inspector they did not lose any items of clothing and were complimentary of the way their clothes were laundered. All residents clothes were neatly labelled.

Judgment:

Non Compliant - Moderate

Outcome 18: Suitable Staffing

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

Theme:

Workforce

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

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

Findings:

There was an actual and planned staff duty roster available for the centre however hours of duty were not stated in start and end timescale format. The person in charge had responsibility for two designated centres but was based in St Mary's Hospital designated centre on a day to day basis. On the days of inspection, the person in charge was on leave. The deputy person in charge for this centre is based on-site and facilitated this inspection. The deputy person in charge works up to 17:30 five days per week and together with two staff nurses and five carers was engaged in the operational management of the centre. There was no evidence that staffing levels were assessed at all times of the day and night to ensure they were adequate to safely evacuate residents in the event of fire.

Care staff were multi-task attendant grade and in addition to care of residents, they also managed, catering assistant, cleaning, laundry and activities for residents as part of their role. While staff changed their uniforms, the duty roster did not identify individual staff roles or the hours they were engaged in these various roles. This finding requires review. The inspector observed that residents' supervision needs were met on the days of inspection with the exception of a resident who remained in their bedroom throughout the days of inspection. This finding requires immediate review. There was no designated activity co-ordinator to ensure each resident's interests and capabilities were appropriately assessed with provision of an individualised activity programme that empowered their choice and fulfilment.

The inspector reviewed the staff training records and found that staff had engaged in a variety of training facilitated to meet their professional development and meet the needs of the residents in the centre. However, no member of staff had completed training in recreational activity assessment and facilitation including provision of activities to meet the needs of residents with dementia care needs. There were eight residents with documented mental health conditions.

All nursing staff registrations with An Bord Altranais agus Cnáimhseachais na hÉireann were up to date.

A sample of four staff files reviewed contained information required by schedule 2 of the regulations.

There was no volunteer staff working in the centre. External service providers such as the hairdresser and persons facilitation sessional activities were appropriately vetted

Judgment:

Non Compliant - Moderate

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:

Catherine Rose Connolly Gargan
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:	Oriel House
Centre ID:	OSV-0000689
Date of inspection:	13/04/2015
Date of response:	29/06/2015

Requirements

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

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

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

Residents' needs in relation to their safe transition to their new accommodation in St Mary's Hospital was not adequately addressed on the days of inspection and requires comprehensive assessment and review to ensure residents' needs are met. A plan is required to detailing the transition process including timescales for each stage of the process.

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

Action Required:

Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015

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

- The Registered Provider, the Person in Charge and the CNM2 have held a number of detailed communication meetings with residents and their families as part of the preparation of the transition to St. Mary`s Castleblayney.
- Minutes of these meetings are available for inspection.
- All residents and families have been encouraged and provided with the opportunity to view St. Mary`s on a number of occasions and a number of residents have already engaged in this process. This process remains ongoing until the transition takes place.
- The Registered Provide will ensure the safe transition of the residents from Oriel House to St. Mary`s.
- The Registered Provider will ensure that each resident will have a comprehensive risk assessment to ensure resident needs are met.
- A detailed plan of the transition process including time scales for each stage will be available by 31st August 2015.

Proposed Timescale: 31/08/2015

Theme:

Governance, Leadership and Management

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

Comprehensive analysis of findings is required in a number of areas monitored to ensure improvements are appropriately implemented.

Action Required:

Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

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

The Registered Provider will ensure that Oriel House has sufficient resources to ensure the effective delivery of care and this is reflected in the statement of purpose.

Proposed Timescale: 25/06/2015

Outcome 05: Documentation to be kept at a designated centre**Theme:**

Governance, Leadership and Management

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

The policy advising on protection of vulnerable persons was missing some relevant advisory information and was not centre specific.

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:

The Registered Provider has updated and implemented a revised policy on the protection of vulnerable persons. This policy is centre specific. It contains clear guidelines and information advising staff on how they would deal with an allegation of abuse against a senior staff member. The name and the phone number of the senior social worker are clearly identified in the policy.

Proposed Timescale: 25/06/2015

Theme:

Governance, Leadership and Management

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

The duty rota did not contain adequate information to determine whether the roster was actually worked as required by Schedule 4, paragraph 9 of the regulations. The document did not reference the periods worked by staff in the centre.

Records of fire drills completed were not available for review on this inspection as required by Schedule 4, paragraph 10 of the regulations.

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:

- The Registered Provider has amended the duty roster to identify and to determine the periods actually worked by staff in the centre.
- The fire register log book and staff training matrix contains information in relation to fire training including fire drills. There is also a record of a weekly test of fire equipment and fire alarm. All available for inspection.

Proposed Timescale: 25/06/2015

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

Some residents were using full-length bedrails as enablers which placed limitations on their freedom to access their bed independently. This finding did not support use of bedrails in accordance with national policy on restraint as published on the website of the Department of Health.

Action Required:

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

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

- All residents who use bed rails will have a comprehensive risk assessment carried out.
- Full length bedrails will each be reviewed and if required will be removed/replaced with half bed rails
- A MDT decision is made and a MDT prescription is signed for all residents who require bedrails.
- The decision to review the need for bedrails is reviewed every 24 hours by 2 members of the nursing staff in accordance with the national and local policy on restraint.

Proposed Timescale: 31/08/2015

Theme:

Safe care and support

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

The security arrangements and supports required review due to the remoteness of the site and the absence of secure perimeter fencing or otherwise to ensure all measures were taken to protect residents and staff working in the centre.

A resident used a remote unapproved path to access the local town. Review of this arrangement is required to ensure reasonable measures are taken to ensure this resident's protection needs are met.

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:

The Registered Provider will review the security arrangements to ensure that all appropriate measures are taken to protect residents and staff working in the centre.

- External CCTV is in place around the exterior perimeter of the building.
- Access to the unit is restricted by the use of a coded key pad.
- There is a direct telephone line to the local garda station which is situated

approximately 2 minutes away.

- There is a local security policy in place and staff are aware of the processes in place and vigilance required.
- Security is a standard item discussed at team meetings.
- Security is identified as a risk in the risk register and the risk escalated accordingly.
- The staff has a direct telephone link to the Blackwater house which is adjacent 24 hour residential unit if required.
- A comprehensive risk assessment is updated monthly for the resident who accesses the town independently and whom occasionally uses the remote pathway. All measures are in place to minimise this risk as far as is reasonably practicable. This is available for inspection.
- All staff have been trained in elder abuse training, recorded on the training matrix and a local policy on The Prevention, Detection and Response to Abuse is in place in the centre.

Proposed Timescale: 25/06/2015

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:

Some risks that were not identified and risk assessed in the risk register with stated concomitant controls to mitigate the level of risk found. These risks are described in outcome 8

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:

- The uneven road surface had been identified in the risk register and this risk has since been resolved.
- The Security risk continues to be recorded in the risk register and escalated accordingly.
- The risk register now contains the risk that vehicular traffic in close proximity to the centre poses to residents.

The major capital refurbishment planned for this centre will address many of the issues currently identified in the risk register. This work is due to commence Sept/Oct 2015 and will be complete Sept/Oct 2016.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

Procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were not implemented and are described in outcome 8

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:

- The wooden base surrounding the bedpan washer has been replaced and can now be adequately cleaned to meet the standard.

Proposed Timescale: 20/06/2015

Theme:

Safe care and support

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

While there was evidence that staff had completed fire drills in the training records, there was no record maintained of the fire drills completed including evidence that fire drills were simulated to account for day and night-time conditions including staffing levels to ensure adequacy to execute evacuation if necessary.

Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

The Registered Provider will ensure all staff are trained in fire prevention, control and evacuation.

- Each resident has an individual evacuation plan.
- Simulated evacuation procedures using minimal day and night time staffing levels will be carried out.
- A record will be maintained in the centre and available for inspection.
- A comprehensive fire policy and emergency evacuation policy is in place in the centre which identifies the processes involved in safe placement of the residents.

Proposed Timescale: 20/06/2015

Theme:

Safe care and support

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

Bulk storage bins were located in the pathway of a fire exit.

The fire exit door in the residents' sitting area had a curtain fitted over it. While a key was in a break-glass unit adjacent to this door, it was locked on the days of inspection.

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:

- The Registered Provider has had Bulk storage bins removed from the fire exit and re-located.
- An additional key to open the resident`s sitting room door has been provided and all staff are aware of its location.

Proposed Timescale: 20/06/2015

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:

While medication audits were completed, this was done by staff in the centre and not by the pharmacist in line with obligations as described by the Pharmaceutical Society of Ireland.

Action Required:

Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

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

- PIC will arrange for the pharmacist to carryout medication audits.
- The outcome of these audits will be presented to staff and if any actions are required.
- A meeting with the pharmacist and the PIC took place on 25/06/15 with regard to the implementation of the relevant legislation issued by the Pharmaceutical Society of Ireland and to ensure the pharmacist meets his/her obligations to the residents in the centre.
- Met with pharmacist on the 25/06/15 the following action were agreed
 1. From Sept 2015 medication audits will be carried out monthly.
 2. Outcomes of audits will be discussed with the PIC and the CNMs and if required an

action plan written up

Proposed Timescale: 30/09/2015

Theme:

Safe care and support

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

The pharmacist was did not regularly attend the centre and was therefore not available to residents.

Action Required:

Under Regulation 29(1) you are required to: Make available to the resident a pharmacist of the resident's choice or who is acceptable to the resident.

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

- The PIC will ensure the pharmacist will regularly attend the centre and is available to the residents.
- Will be available to meet with the residents to discuss any issues or concerns they may have.
- Provide education sessions on medications to the residents in groups or on a one to one.
- There is also a GP and a nurse prescriber on site to give advice and support to residents with regard to their medications.

Proposed Timescale: 30/09/2015

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:

Quarterly notifications were forwarded however the notification on restraint use did not include use of lap-belts.

Action Required:

Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

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

- The PIC now includes the number of lap belts in the Quarterly notification sent to HIQA.

Proposed Timescale: 20/06/2015

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

A resident with challenging behaviour that negatively impacted on their quality of life was not referred as appropriate to psychiatry of older age and/or behavioural therapy as advised by their 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:

- The PIC will ensure that a resident with challenging behaviour that impacts negatively on their quality of life will be referred to psychiatry of old age and /or behavioural therapy this will be documented in their care plan.
- The PIC ensures a comprehensive nursing care plan remains in place which states that the resident will be re-referred to the psychiatrist/behavioural therapist if the challenging behaviour increases in frequency, intensity or duration.
- A re- referral to the psychiatrist and behavioural therapist has been made by the medical officer and the resident has been reviewed accordingly.
- Following assessment by the team of psychiatry of old age a comprehensive care plan will be developed for this resident.

Proposed Timescale: 20/06/2015

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:

The inspector found that the design and layout of the bedroom accommodation, an en-suite in a five bedded room and communal toilet and shower facilities did not met their stated purpose.

Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

- A major capital refurbishment is planned for this centre. These capital works will involve the building of 20 single ensuite rooms and refurbishment of the existing building.
- The Register Provider will ensure the refurbishment of Oriel House will meet the needs of the appropriate number of residents.
- The planned refurbishment project for Oriel House is due to commence in Sept/Oct. 2015 and will meet the regulations required.

Proposed Timescale: 30/09/2016

Theme:

Effective care and support

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

The premises did not conform to the matters in all respects as set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Paint and parts of the surface of the wood were missing and as such it could not be adequately cleaned

Action Required:

Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

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

- The Register Provider will ensure that the premises will conform to the matters in all respects as set out in Schedule 6 having regard to the needs of the residents.

Proposed Timescale: 31/10/2016

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:

All correspondence and details of the investigation were not filed together to reference full and properly completed complaint record- keeping. Therefore, correspondence sent to one complainant as an outcome of investigation was not available for review on this inspection.

Action Required:

Under Regulation 34(2) you are required to: Fully and properly record all complaints

and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident's individual care plan.

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

- The Registered Provider ensures all communication with regard to any complaint recorded and investigated are now filed together.
- The outcome of the complaint is clearly documented in the complaints log and available for inspection.

Proposed Timescale: 20/06/2015

Theme:

Person-centred care and support

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

A record of complainants' satisfaction with the outcome of investigation of complaints was not consistently documented.

Action Required:

Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

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

- The Registered Provider ensures that following investigation and resolution of any complaint clear documentation will be maintained.
- Identifying the outcome of the complaint and the level of satisfaction expressed by the complainant will be clearly recorded and available for inspection.

Proposed Timescale: 20/06/2015

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:

Records were available that recorded residents' participation in activities but did not record adequate information to conclude the activity they participated in adequately met their interests and capabilities.

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 Registered Provider has ensured a variety of activities are provided to meet the needs, interests and capabilities of all the residents.
- This information is available in the residents individual care plans as well as the weekly activity timetable schedule.
- The daily individual record activity sheet for residents has been amended and clearly identifies and records the level of resident participation and enjoyment in the activity provided. This is available for inspection.

Proposed Timescale: 20/06/2015

Theme:

Person-centred care and support

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

While residents were generally informed of plans for refurbishment of their home, the inspector did not find adequate evidence to confirm that a comprehensive consultative process was in place to ensure residents and their families were fully informed and involved in all aspects of the project.

Action Required:

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

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

- The Registered Provider will ensure that all residents are consulted about and are involved in the organisation of the centre.
- Residents have been shown draft plans for the refurbishment and asked for there feedback/comments.
- Final Plans will be put on prominent display for residents and relatives to see.
- Residents will be provided with the opportunity to be actively involved in the choosing of interior décor, furniture etc when the refurbishment project of Oriel House is near completion.

Proposed Timescale: 31/10/2016

Theme:

Person-centred care and support

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

The layout and design of residents' bedroom accommodation did not ensure their privacy and dignity needs were met.

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:

The Registered Provider, the PIC and the CNM2 are acutely aware that the current layout of the bedrooms leaves it extremely difficult to maximise independence, privacy and dignity for the residents,

- The PIC and the CNM2 continue to work with staff to ensure that current resident's privacy and dignity is maximised within the physical constraints of the multi occupancy bedrooms.
- Currently all bedroom doors are closed when personal care been attended to and clear signage is evident on the bed room doors to this effect.
- Individual bed screens can be pulled around each bed to ensure privacy is maintained.
- Each resident is provided with a locker and wardrobe which has a lockable space for personal effects.
- A visitors room is available for residents who wish to conduct private matters.

A major capital refurbishment is planned for this centre. These capital works will involve the building of 20 single ensuite rooms and refurbishment of the existing building.

- The Register Provider will ensure the refurbishment of Oriel House will meet the privacy and dignity needs of the appropriate number of residents.
- The planned refurbishment project for Oriel House is due to commence in Sept/Oct. 2015 and will meet the regulations required.

Proposed Timescale: 31/10/2015

Theme:

Person-centred care and support

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

There was no evidence in each resident's documentation regarding assessment to ensure their wishes were addressed regarding practising their religious beliefs.

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:

- The Registered Provider has ensured that each residents care plan clearly identifies and documents their wishes in relation to there religious beliefs and religious practices. This is available for inspection.

Proposed Timescale: 20/06/2015

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:

Each resident did not have reasonable space to store and maintain his or her 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:

- The PIC has provided a number of residents with an additional wardrobe for their personal effects and one bedroom has a large slider robe which is used in addition to store residents' personal effects.
- The planned refurbishment of Oriol House will provide each resident with substantial space to store their personal effects.
- Adequate storage space for the residents' clothes and personal possessions will be made available when the transition to St. Mary's takes place end of Aug 2015.

Proposed Timescale: 31/10/2016

Outcome 18: Suitable Staffing**Theme:**

Workforce

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

A review of the staffing numbers and skill mix was required to ensure residents' needs were met including supervision of residents who remained in their bedrooms, clarification of roles of multi-task attendants. There was insufficient staff to provide activities to residents who remained in their bedrooms. This finding requires immediate review.

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:

The Registered Provider will ensure that there are sufficient numbers of staff to provide activities for residents who remain in their bedroom.

- The PIC has ensured that a comprehensive assessment is carried out on each resident to identify their needs and the number and the skill mix of staff is appropriate to meet needs of the residents.
- The roles of the multi task attendants are clearly outlined on the roster daily using a

colour coded system to indicate their role.

- Supervision and individualised activities are provided daily for the residents who remain in bed.

Proposed Timescale: 12/06/2015

Theme:

Workforce

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

No member of staff had completed training in recreational activity assessment and facilitation including provision of activities to meet the needs of residents with dementia care needs.

Action Required:

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

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

The PIC will ensure access to appropriate training for staff to provide activities to meet the needs of residents with dementia care needs.

- 7 Staff have completed a 2 day Dementia Care programme – 2013
- 6 Staff have completed a 2 day Sonas programme – 2011
- 2 Staff have completed a part time 9 month programme on Therapeutic Arts for Older People 2007

This information is now clearly evident in the staff training matrix.

Proposed Timescale: 25/06/2015