

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Gowran Abbey Nursing Home
Centre ID:	OSV-0000232
Centre address:	Gowran, Kilkenny.
Telephone number:	056 772 6500
Email address:	info@gowranabbeynursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Gowran Partners T/A Gowran Abbey Nursing Home
Provider Nominee:	Finian Gallagher
Lead inspector:	Ide Cronin
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	51
Number of vacancies on the date of inspection:	0

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 27 April 2016 09:15 To: 27 April 2016 18:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Non Compliant - Moderate
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant
Outcome 08: Governance and Management		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also followed up on progress of the action plans from the last inspection of the centre in April 2014 and reviewed notifications and other relevant information.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Health Information and Quality Authority (HIQA). In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process. The provider had assessed the compliance level of the centre through the self assessment tool. Inspectors followed the experience of a number of residents with dementia within the service. They observed care practices and interactions between staff and residents who had

dementia, using a validated observation tool.

The findings of this inspection are not in agreement with the provider's assessment of compliance in six outcomes. Inspectors found that the centre was compliant or substantially compliant in four out of the seven outcomes that were inspected. Inspectors also added the outcome of governance and management which was found to be at a level of moderate non compliance. Inspectors observed that the management team and staff working in the centre were committed to providing a quality service for residents with dementia. Inspectors observed practices and reviewed documentation such as care plans, medical records, allied health care records, policies and the planned activity programme. A number of staff files and residents' files were checked for relevant documentation.

It was found that progress was made by the provider in implementing the required improvements identified by the registration inspection. However, further improvements were required following this inspection which included:

- *Care planning
- *End of life care
- *Aspects of the premises
- *Governance and management.

Matters requiring review are discussed throughout the report and the action plan at the end of the report contains actions that are required to be completed 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.

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: Health and Social Care Needs

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 pre admission assessment was generally conducted by the person in charge who looked at both the health and social needs of the potential resident. Transfer of information within and between the centre and other healthcare providers was found to be good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were seen. Inspectors reviewed a number of residents' files in detail and observed that residents had a comprehensive assessment and care plan in place to meet their assessed needs. There was a good emphasis on personal care and ensuring personal wishes and needs were met.

Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores and moving and handling assessments. Staff demonstrated good knowledge and understanding of each resident's background in conversation with the inspector. Whilst the person in charge and staff told the inspector that residents/relatives were involved in the care planning process there was limited documentary evidence that residents or their representative were involved in the development and review of their care plan.

Care plans for residents with dementia or behaviours that challenge required review to ensure they are more person centred. Inspectors observed that the plans were not specific enough to guide staff and manage the needs identified. Inspectors observed that where a small number of residents exhibited aspects of behaviour that challenged, which were related to the behavioural and psychological symptoms of dementia (BPSD) their care plan required improvement. The care plans did not describe effective positive behavioural strategies for use by staff to manage these behaviours. The care plan in place to manage these needs did not fully guide staff on the signs to look for as potential triggers to responsive behaviour. The plans also did not guide staff on the type of distraction techniques which could be employed to reduce escalation or of all measures which were known to manage the behaviour and prevent recurrence. Although it was found that staff were familiar with their residents needs and could

recognise changes to their demeanour, for new, inexperienced or replacement staff care assessment and planning documentation was not sufficiently explicit to direct care.

Residents had access to GP services and there was evidence of medical reviews frequently. It was evidenced in medical files new residents were seen by the GP within a short timeframe of admission. The psychiatrist and their team visit the centre as required to review residents. Medication is reviewed to ensure optimum therapeutic value. Access to allied health professionals to include speech and language therapist, dietetic service and occupational therapy were available. Specialised supportive equipment including pressure relieving mattresses and cushions were used as preventive measures. Supportive aids were evident including walking frames and residents were individually supported to maintain their independence as their capacity allowed.

There were assessment and care procedures in place to ensure residents' nutritional needs were met and that they did not experience dietary or hydration deficits. Residents' weights were checked on a monthly basis. Diet and fluid intake records were used as appropriate. Menus were available and all residents were offered choice at each meal. There was evidence of efforts made to ensure residents with dementia had their individual food tastes and choices met. Residents were discreetly assisted with eating by staff that were observed to encourage residents to maintain their independence with eating and drinking.

There were no residents in the centre in receipt of end of life care on the day of inspection. Palliative care services were available to support residents and staff with symptom control, including pain management. However, there was inconsistent evidence that the end of life needs and wishes of all residents' with dementia were discussed with them and/or their next of kin as appropriate and documented in a care plan. Some care plans addressed the resident's physical, emotional, social and spiritual needs. Some care plans did not reflect each resident's wishes and preferred pathway as part of their end of life care. It was not evident in the documentation reviewed that the resident was involved in the decision making process relating to end of life care.

There were written operation policies relating to the ordering, prescribing, storing and administration of medicines to residents and disposal of unused or out-of-date medicines. The inspector reviewed a sample of residents' individual medicine prescription charts and there was evidence that residents' prescriptions were reviewed at least three monthly by a medical practitioner. The medication administration sheets viewed were signed by the nurse following administration of medication to the resident and recorded the name of the drug and time of administration.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were clear and The signature of the GP was in place for each drug prescribed in the sample of drug charts examined.

The supply, distribution and control of scheduled controlled drugs was checked and deemed correct against the register in line with legislation. Inspectors saw that medication management audits had not been completed recently. Staff told inspectors

that the pharmacist would visit to check stock control regularly and had just commenced routinely meeting with residents

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that measures were in place to protect residents and to respond to allegations of abuse.

There were policies in place for the prevention, detection, reporting and investigating allegations or suspicions of abuse. Inspectors spoke to members of staff during the inspection who knew what action to take if they witnessed, suspected or had abuse disclosed to them. Staff could also identify who they would report a suspicion or allegation of abuse to. However, training records indicated that only 43 of 63 staff had completed training in the prevention, detection and management of abuse.

An inspector reviewed a sample of residents' money kept on their behalf in the centre, which are securely stored in a safe. Individual records are kept for the various services provided in the centre, such as hairdressing or chiropody. Any withdrawals or lodgements into residents' accounts are recorded and a copy of these transactions are given to the residents' families every three months. The person managing residents' finances checks all balances once a month, and a sample of balances checked by inspectors were correct.

There was a policy in place for managing challenging behaviour. Inspectors viewed records showing that 9 staff members have been trained in responsive behaviours. Inspectors observed staff successfully use de-escalation techniques to diffuse a situation between two residents during the inspection. However, inspectors found that residents with challenging behaviour did not have a care plan that sufficiently informed their care. This is described in detail in Outcome 1, Health and Social Care Needs.

There was also a policy and procedure in place for the use of restraint. Any residents using restraint were recorded in the centre's risk register. A high number of residents had bed rails in place, however, staff could evidence that risk assessments were completed and appropriate alternatives were trialled for residents prior to use of restraint. Two hourly checks were carried out on residents while bed rails are in place, and these were recorded. Inspectors viewed records for a number of residents using bed rails and found that most records were in line with the centre's restraint policy and procedures. However, inspectors saw that a resident who had fallen a number of times

since admission had not received a follow up assessment after each fall, which did not correspond with the centre's procedures.

Judgment:

Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence of a good communication culture amongst residents and the staff team. Inspectors observed that residents were well dressed. Personal hygiene and grooming were well attended to by care staff. The inspectors observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times. Residents were able to exercise choice regarding the time they got up and were able to have breakfast at a time that suited them. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends in the dining areas or communal rooms.

Residents were consulted about how the centre was planned and run through the residents' forum. The inspector viewed minutes from previous meeting of January 2016. The inspector noted that issues in relation to lack of supervision in the communal room were discussed. This was also observed by inspectors during inspection. The person in charge and/or the assistant director of nursing met with residents on a daily basis and sought feedback. Activities for residents were available four days per week. Inspectors saw that the activity programme was varied such as movie afternoons, arts and crafts, music and exercises. One resident goes out to the local day centre.

The person in charge informed the inspector that 1:1 time was scheduled for residents with more severe dementia or cognitive impairment who could not participate in the group activities, and that this time was used for sensory stimulation such as providing hand massages. Other dementia relevant activities were included in the programme. Residents were facilitated to exercise their civil, political and religious rights. Residents could attend mass in the centre as there was an oratory on site. The person in charge said that in house voting had been facilitated for the most recent elections.

Inspectors used a validated observational tool to rate and record at five minute intervals the quality of interactions between staff and residents in the centre. The observation tool used was the Quality of Interaction Schedule or QUIS (Dean et al 1993). These observations took place in the lounge areas and in the dining area of the centre. Each observation lasted a period of 30 minutes and inspectors evaluated the quality of interactions between staff and residents with dementia.

Some positive interactions between staff and residents were observed during the inspection. However, inspectors observed that staff did not avail of opportunities to socially engage with residents. It was also observed that many staff did not engage residents in conversation except when engaging in tasks. Staff were observed to pass through the sitting room without speaking to residents. There were periods during the observation when the communal room was left unsupervised. Although staff seemed familiar with residents' basic physical care needs and their family backgrounds, opportunities to chat to them about their family, previous interests or working life were limited.

Overall, observations of the quality of interactions between residents and staff in the communal area for a selected period of time indicated that the majority of interactions were of a neutral nature. Inspectors observed that for the majority of the residents in the communal area, there were no meaningful interactions with staff. Most residents were not engaged, or were asleep in their chairs with no stimulation for periods of time. During the lunch time period staff were observed for the most part to offer assistance in a respectful and dignified manner. There was one instance observed by inspectors where a staff member took the fork away from the resident and proceeded to feed the resident the remainder of the meal. Inspectors observed that when interactions did take place they were task orientated, such as asking the resident if they wished to have a drink. Inspectors found that during the observation periods that practices were led by routine and resources. Inspectors discussed these findings in detail with the person in charge who agreed with the findings in relation to the observations.

Inspectors observed that notices were on display which indicated that residents and their representatives were provided with contact information for independent advocacy services. However, a resident told an inspector that he was not aware of the advocacy services available. Residents had a section in their care plan that covered their communication needs. There was a communication policy in place.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

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

Findings:

A written complaints policy was available in the centre, and was displayed prominently in the reception area. This policy had been updated since the last inspection to include a nominated independent appeals person, as required by legislation. However the format

of the policy prevented it from being accessible to all residents, particularly those with dementia.

Inspectors spoke to a resident and another resident's family member about the complaints procedure. A family member stated that any complaints made had been resolved to their satisfaction. Inspectors viewed the complaints log and found that records in relation to a complaint made in 2014 had not been maintained. There was no indication whether the complaint had been closed out, what actions had been taken or if the complainant was satisfied with the outcome. Inspectors also viewed records that showed that several concerns had been made to the centre.

These concerns were dealt with in a timely fashion and included details of the interventions taken, the reason for closing the concern, the lessons learned and whether the person who made the concern was satisfied with the result. Inspectors noted that concerns were not included in the complaints policy, and were not satisfied that complaints were being dealt with in line with their own policy. The centre must review its complaints policy and procedure to ensure that complaints are being recorded accurately and are being dealt with promptly and effectively.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors found that the levels and skill mix of staff on the day of the inspection were sufficient to meet the needs of residents, which was confirmed by the actual staff roster.

Inspectors were satisfied that there were effective recruitment procedures in place for selecting, vetting and recruiting staff. Inspectors examined a number of staff files and found that all contained the documents required by Schedule 2 of the regulations, with the exception of a recent photograph of one staff member. Staff files also featured up to date An Bord Altranais professional identification numbers (PIN) for registered nursing staff.

Suitable arrangements were in place for periods of absence of the person in charge and the provider complied with responsibilities to notify the Authority when a change occurred to both the person in charge and the nominated person to replace them. Inspectors spoke with varied staff members and found that they were knowledgeable about residents' individual needs, fire procedures and the system for reporting suspicions or allegations of abuse. Staff told the inspector that they were well supported

and said that the person in charge provided good leadership and guidance.

Inspectors viewed training records confirming that staff were engaging in ongoing professional development, for example, training in medication management and dysphagia awareness. Training in fire safety and manual handling was also being held in the centre on the day of the inspection.

Judgment:

Compliant

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The premises is fit for its stated purpose. The centre was observed to be bright, furnished to a high standard and clean throughout. There were appropriate pictures, furnishings and colour schemes. Bedroom accommodation consists of 51 single ensuite rooms. There were appropriate beds and mattresses to meet residents' needs. The design and layout of the single bedrooms provides sufficient space and bedroom furniture for each resident.

There was a large dining room, day room, oratory and a large multi-purpose room which was used for activities, visits, and celebratory occasions for residents and their families. A smoking room, combined treatment room and appropriately equipped hairdressing room is provided. Two nurses' stations, administrative offices, suitably equipped kitchen and laundry complete the accommodation. There were suitable facilities available for staff.

There are four assisted toilets and one assisted bathroom for residents' communal use. There are two enclosed courtyard gardens with seating which residents. The premises and grounds were well-maintained. A maintenance person was employed. The inspector observed that CCTV was in use to maintain the safety of the residents. It did not impinge on the privacy and dignity of residents. Two safe and secure gardens were available and directly accessible to residents.

Some improvements to the premises were found to be required specifically for residents with dementia. Appropriate signage and cueing to support freedom of movement for residents with dementia was not evident. Picture cueing on dining area, bathrooms and toilet areas was used but needed to be improved. Floor coverings were appropriate in some areas but not in all areas used by residents with dementia. Contrasting colours were not used in bathrooms and toilets. Inspectors observed that equipment to stimulate and engage residents with dementia was available but limited in supply.

Judgment:

Substantially Compliant

Outcome 08: Governance and Management**Theme:**

Governance, Leadership and Management

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

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

Findings:

Inspectors found that the system in place to monitor the quality and safety of care and the quality of life for residents required improvement. There were directors meetings which were held on a fortnightly basis which dealt with accounts, training, staffing, dependency levels, resident safety, supervision and any other business. Inspectors found that the management systems were ineffective in monitoring the delivery of safe and quality care services to residents.

The inspectors observed that clinical and non clinical audit had not been carried out for over a year. Therefore the quality of care and experience of residents was not monitored effectively as deficits in practice were not identified and could not positively inform improvements in the safety and quality of care or the quality of life of residents. This was also raised on the previous inspection in 2014. An annual review of the quality and safety of the service as required by legislation for 2015 was not available to inspectors or residents on this inspection.

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:

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

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Gowran Abbey Nursing Home
Centre ID:	OSV-0000232
Date of inspection:	27/04/2016
Date of response:	30/05/2016

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: Health and Social Care Needs

Theme:

Safe care and support

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

Residents capacity was not assessed or reviewed prior to their involvement in decisions regarding consent to level of care interventions at end of life stage.

1. Action Required:

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of

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

a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

Documentation on end of life care choices based on Professor D William Molloy's publication "Let Me Decide" is provided to all intending residents and or representatives as appropriate as part of the admission information pack provided on initial enquiry for care

The pre assessment documentation has been improved to capture the end of life care choices of intending residents when the assessment is carried out by the person in charge or the assistant director of nursing.

Proposed Timescale: 30/05/2016

Theme:

Safe care and support

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

There was limited documentary evidence that residents or their representative were involved in the development and review of their care plan

2. Action Required:

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

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

The provision of care plans based on the residents assessed needs will be made available to and or discussed with residents and family members or representative as appropriate following admission and on review and documented.

Proposed Timescale: 31/05/2016

Theme:

Safe care and support

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

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.

3. Action Required:

Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after

that resident's admission to the designated centre.

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

An audit of all care plans is in progress following the inspection and will be revised to ensure the residents assessed needs are documented to direct the individual resident's needs. A care planning workshop will be facilitated by an external facilitator to upskill nursing staff and recently recruited to document care and comply with regulation.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

The care plans did not always describe effective positive behavioural strategies for use by staff to manage behaviours. The care plans in place to manage these needs did not fully guide staff on the signs to look for as potential triggers to responsive behaviour.

4. Action Required:

Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

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

The recently appointed assistant director of nursing who has a diploma in dementia care has commenced training on responsive behaviours for all disciplines of staff to recognise triggers and implement strategies to manage responsive behaviours. The care planning workshop will assist nursing staff to document clearly the triggers and strategies to deescalate responsive behaviours for individual residents

Proposed Timescale: 31/07/2016

Theme:

Safe care and support

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

Some care plans did not reflect each resident's wishes and preferred pathway as part of their end of life care.

5. Action Required:

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

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

All care plans are being reviewed, discussion will take place with the resident or relative as appropriate to establish the end of life care wishes of each individual resident. The resident's GP will be involved in the process. The resident's wishes will be documented and reviewed to direct the end of life care.

Proposed Timescale: 17/06/2016

Outcome 02: 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:

Ensure that all staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

6. 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:

The assistant director of nursing has put in place a schedule of training for all disciplines of staff. Four of the current nursing staff including the director of nursing have availed of when available the three day national dementia care and responsive behaviours programme facilitated by the HSE. The community liaison nurse in psychiatry in later life is facilitating an in - service training workshop on responsive behaviours on the 8 June 2016.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

Inspectors saw that a resident who had fallen a number of times since admission had not received a follow up assessment after each fall, which did not correspond with the centre's procedures.

7. 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:

The audit process of incidents / accidents, assessments and care planning will drive and support staff in ensuring safe and appropriate care is provide for residents.

Proposed Timescale: 30/06/2016

Theme:

Safe care and support

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

Training records indicated that only 43 of 63 staff had completed training in the prevention, detection and management of abuse.

8. Action Required:

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

The training days scheduled by the assistant director of nursing is facilitating detection, prevention and responding to elder abuse and responsive behaviours for all staff disciplines.

Proposed Timescale: 30/06/2016

Outcome 03: 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:

Opportunities for meaningful engagement with residents were not appropriately responded to by staff.

9. 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 provides a varied programme of activities suitable to meet the needs of all the residents including one to one session for residents who do not wish to or are unable to participate in the various group sessions.

Discussion has taken place with all disciplines of staff to avail of opportunities to have positive meaningful engagement with residents and what that engagement means. Care assistants are now facilitating an activity in the afternoons in the absence of the activity coordinator. On the day of the inspection training was in progress in the front room

where normally residents are invited to a movie afternoon.

Proposed Timescale: 31/05/2016

Theme:

Person-centred care and support

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

A resident told an inspector that he was not aware of the advocacy services available.

10. Action Required:

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

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

A list of the advocacy services available for residents is included in the Residents' Guide provided to each resident or relative making enquiries for admission to the nursing home. The SAGE Support and Advocacy Services for Older People poster with contact phone number is pinned to the notice board in the reception area and at both of the nurses' stations. On the day of inspection a thank you card had been pinned over the reception poster. The poster is now included in the resident information pack and is also displayed in each bedroom. The availability of advocacy services will be highlighted at residents and family meetings held quarterly

Proposed Timescale: 30/05/2016

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

The complaints procedure was not accessible to all residents

11. Action Required:

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

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

The complaints procedure as displayed in the reception area is included in the resident guide provided to resident or relative on initial enquiry. A complaints form is provided with the guide.
A six point clear print pictorial poster is now provided in each bedroom on how to make a complaint. Complaints will be tabled as an agenda item for resident / relatives meetings quarterly.

Proposed Timescale: 30/05/2016

Theme:

Person-centred care and support

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

The nominated person had not maintained 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.

12. 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:

Complaints, concerns or any issue raised will be managed in line with policy.

Proposed Timescale: 30/05/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

Picture cueing in the dining area, bathrooms and toilet areas was used but needed to be improved to meet the needs of residents with dementia.

13. 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:

Improved signage has been put in place for communal toilets and ensuites since the inspection, improvements with contrasting colours through the building will be made as will be practical and appropriate.

Proposed Timescale: 31/08/2016

Theme:

Effective care and support

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

Floor coverings were appropriate in some areas but not in all areas used by residents with dementia. Contrasting colours were not used in bathrooms and toilets to meet the needs of residents with dementia.

14. 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 flooring in the ensuites and bedrooms is non slip. The financial cost of making changes in these areas is prohibitive. Contrasting colour will be used to identify toilets and hand rails as appropriate.

Proposed Timescale: 31/08/2016

Outcome 08: Governance and Management

Theme:

Governance, Leadership and Management

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

Inspectors found that the management systems were ineffective in monitoring the delivery of safe and quality care services to residents. The inspectors observed that clinical and non clinical audit had not been carried out for over a year.

15. Action Required:

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

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

The audit process has recommenced tracking monthly KPI's. Feedback will be provided on a three monthly basis at management meetings, staff, residents and family meetings.

Proposed Timescale: 30/06/2016

Theme:

Governance, Leadership and Management

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

An annual review of the quality and safety of the service as required by legislation for 2015 was not available .

16. Action Required:

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

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

The annual review on quality and safety will be compiled for 2015 by 30 June 2016 and will be completed annually by 31 January thereafter.

Proposed Timescale: 30/06/2016