

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Strawhall Nursing Home
<b>Centre ID:</b>	OSV-0000295
<b>Centre address:</b>	Strawhall, Fermoy, Cork.
<b>Telephone number:</b>	025 31 678
<b>Email address:</b>	strawhallnursinghome@eircom.net
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Strawhall Nursing Home Partnership
<b>Provider Nominee:</b>	Margaret Rice
<b>Lead inspector:</b>	Mary O'Mahony
<b>Support inspector(s):</b>	None
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	28
<b>Number of vacancies on the date of inspection:</b>	2

## About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

**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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

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

From:	To:
17 October 2016 10:30	17 October 2016 18:45
18 October 2016 09:30	18 October 2016 13:45

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Major
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 13: Complaints procedures	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This monitoring inspection of Strawhall Nursing Home by the Health Information and Quality Authority (HIQA) was unannounced and was the eighth inspection of the centre. The centre was established in 1988 and accommodated 30 residents. It was a two-storey building set in well maintained mature gardens. It was located within walking distance of the town of Fermoy. On the first day of inspection one resident was in hospital and there were two vacant beds. However, on the second day of inspection two new residents were admitted to the centre. During the inspection, the inspector met with the provider, the person in charge, residents, relatives, and staff members. The inspector observed care practices and reviewed documentation such as the complaints log, care plans, incident records, policies, fire safety records and staff files. There was an inclusive, welcoming ethos in the centre and a full time activity co-ordinator post had been resourced since the previous inspection. This appointment was welcomed by residents, relatives and staff who all confirmed that residents' lives in the centre were greatly enhanced as a result.

The bedroom layout consisted of 22 single rooms, 10 of which had en suite shower, toilet and wash basin facilities. There were four twin-bedded rooms, one of which had en suite facilities. Ten residents were accommodated on the first floor with the remainder at ground floor level. Two stair lifts were fitted to the stair areas and a lift was available to the first floor. One of these stair lifts had been installed since the previous inspection. There were two mobile residents accommodated on the upper floor of the building in single occupancy bedrooms.

There were a number of comfortable sitting rooms in the centre and there was adequate space for residents to meet visitors in private. The conservatory consisted of two separate but interlinked rooms which faced out onto the gardens. Residents told inspectors that they enjoyed sitting there to read the morning papers and to relax after dinner. The dining room was spacious and well located adjacent to the kitchen. An enclosed courtyard provided residents with a safe recreational outdoor area. Residents had different dependency levels ranging from those who were very active and self caring to more dependent residents with high care needs. The centre also provided facilities for respite residents.

The action plan at the end of the report sets out the areas of non compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland, identified on inspection. Areas of non-compliance included: safeguarding and safety, medication management, staffing and health and safety. The centre was asked to submit a second action plan to set out clearly how issues were going to be addressed.

**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 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):**

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

**Findings:**

The quality of care and experience of the residents were monitored and developed on an ongoing basis. Effective management systems were seen to be in place in the centre. The provider assured the inspector that there were sufficient resources in place to provide for the delivery of safe and quality care to the residents.

The person in charge was supported by an experienced deputy person in charge. There were clear lines of authority and accountability. Detailed handover meetings were held by staff. Since the previous inspection administration support was provided on two mornings per week. The provider stated that she would maintain this under review as a support to the person in charge. The inspector saw evidence of management and staff meetings and found that issues were addressed in a proactive way.

There was evidence of consultation with residents and their relatives. The inspector spoke to residents who said that there were residents' meetings held in the centre. An external person had been interviewed to act as residents' advocate. The person who previously held this position had stepped down. The provider also undertook to make contact with a national advocacy service on behalf of residents.

Relatives spoke to the inspector about the fact that staff frequently consult with them if there is a change in the status of the resident or if any accident occurs. Relatives and residents were also consulted with and informed about infections and HIQA findings, among other relevant issues. The inspector saw minutes of residents' and relatives' meetings which confirmed these statements.

**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 had been in the post for two years. The inspector spoke with her during the inspection and she displayed a detailed knowledge of the standards and regulations for the sector. She was found to be experienced and committed to providing person-centred care for residents and their families. She demonstrated a full awareness of the accountability and responsibility attached to her role. She was involved in the centre every day.

Staff, residents and family members informed inspectors that she was approachable and accessible. The inspector saw evidence of training courses based on best evidence practice, which she had implemented since her appointment.

**Judgment:**

Compliant

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

***The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.***

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

Records required under the Regulations were maintained in the centre. The records viewed by the inspector were accurate and up to date. Records of inspections by other

bodies were maintained.

The Residents' Guide was seen by the inspector and it was informative and comprehensive. Medical records were maintained and the inspector was shown up-to-date restraint and accident logs. The inspector viewed a selection of residents' care plans as outlined under Outcome 11: Health and social care needs. There were centre specific policies which were updated and reviewed when required and these included the policies specified in Schedule 5 of the Regulations. Staff demonstrated an understanding of the policies and signed a document to demonstrate that they had understood the requirements of the policies. Staff with whom the inspector spoke indicated that they were aware of relevant policies.

The centre was adequately insured against injury to residents according to the insurance certificate viewed by the inspector.

Registration details with An Bord Altranais agus Cnaimhseachais na hEireann for nursing staff were available in the sample of staff files reviewed. These files contained most of the regulatory information in relation to matters identified in Schedule 2 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2013. However, some staff did not have the required references on file and the inspector found that there were gaps in employment in some staff CVs (curriculum vitae). This was in contravention of the requirements of the regulations. In addition, in the sample of files reviewed two staff did not have GV in place on the morning of inspection as addressed under Outcome 7. The inspector viewed the directory of residents and it contained the details required under Schedule 3 of the regulations.

Records were viewed by the inspector which indicated that the residents' right to refuse treatment was documented and there were records available to indicate to the inspector that discussion were held with residents and relatives about CPR (Cardio-Pulmonary-Resuscitation).

However, not all complaints were documented as addressed under Outcome 13.

**Judgment:**

Non Compliant - Moderate

***Outcome 07: Safeguarding and Safety***

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

**Theme:**

Safe care and support

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

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

**Findings:**

Policies and procedures were in place for the prevention, detection and response to abuse which references national policies and best evidence practice. Elder abuse prevention training formed part of staff induction. New staff had been scheduled to attend this training. A system was in place to record, monitor, report and investigate incidents, allegations, and or suspicions of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre.

Systems were in place to safeguard residents' money. The provider and administration assistant outlined practices used to record financial transactions and stated that fees were handled separately to personal money/belongings. Personal money transactions were recorded in a lodgement book and signed by two staff members.

Residents were assessed for behaviour issues associated with the behaviour and psychological symptoms of dementia (BPSD) on admission, in line with centre policy. Strategies to de-escalate BPSD were outlined in residents' care plans, where appropriate. However, similar to findings on previous inspections there was no evidence on the staff matrix that staff had received relevant training to update their knowledge and skills in this area of care. Following the inspection the person in charge stated that the training matrix had not been updated at the time of inspection. She stated that this training had been completed in 2014 and was scheduled to be repeated in November 2016.

A restraint free environment was promoted. An assessment of each resident's needs included mental and cognitive functioning, environmental, psychosocial and physical assessments. The inspector reviewed the use of evidence-based restraint assessment forms, restraint risk balance tools and restraint plans in residents' files. Residents or their representatives had given consent for this and a restraint log was maintained. However, the type of restraint belts which were in use on two specialised chairs did not conform to best evidence practice. These residents had not been reviewed by an appropriate allied health professional prior to the use of these restraint belts. The provider was asked to review the use of this type of belt.

In addition, in one care plan reviewed the inspector found that an incident of apparently inappropriate restraint of and bruising to a resident's arm had not been investigated, or properly recorded in the incident book. In addition, a preliminary screening or prevention plan had not been put in place in response to the incident. This was discussed with the person in charge and the provider who stated they would investigate the issue and take appropriate steps to protect the resident. This investigation was forwarded to HIQA following the inspection.

A further safeguarding issue was found when reviewing a sample of staff files. Two staff members were found to have been rostered to work in the centre without the required Garda Vetting (GV) in place. This was required for all staff under the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012-2016. This serious non compliance with legislation was discussed with the person in charge and a verbal immediate action plan was issued by the inspector. The provider was asked to specify in writing the



actions she proposed to take prior to completion of the inspection. One GV was approved before the end of the inspection and the certificate was made available for the inspector's review. The GV application for the second staff member was re-submitted at the time of inspection. The provider stated that this staff member would not be on duty in the centre until this requirement was fulfilled and that no staff member would be allowed on duty without the appropriate vetting in place.

**Judgment:**  
Non Compliant - Major

***Outcome 08: Health and Safety and Risk Management***  
***The health and safety of residents, visitors and staff is promoted and protected.***

**Theme:**  
Safe care and support

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

**Findings:**  
There was a comprehensive emergency plan in place which detailed actions to be taken in the event of emergency situations. It specified the arrangements for the evacuation of residents and identified an external location for the temporary placement of residents. The emergency plan was found to meet the requirements of legislation.

The fire prevention policy was viewed by the inspector and was found to be detailed and centre-specific. There were signs placed prominently around the centre to alert staff and residents to the procedure to follow in the event of a fire. The emergency lighting was checked and serviced at regular intervals and the inspector viewed these records. They were found to be up to date and also indicated that the fire extinguishers were checked and serviced as required.

Fire training was provided to staff on a yearly basis and this also included fire warden training. This annual training was scheduled for all staff in November 2016. Since the previous inspection regular fire evacuation drills were undertaken. Staff spoken with by the inspector were aware of the procedure to be followed in the event of a fire. Fire evacuation blankets were placed on residents' beds and there was an evacuation list at the reception desk which was updated each morning. The fire alarm and the fire doors were checked regularly and the records were checked by the inspector.

The inspector viewed the record of accidents and incidents. Issues were resolved and learning was documented. Clinical risk assessments were undertaken for residents, including falls risk assessment, assessments for dependency and skin integrity, continence, moving and handling and behaviour associated with medical conditions. There was a health and safety lead staff member in the centre and the health and safety committee met weekly. The health and safety staff member informed the inspector that

each Tuesday she had been allocated health and safety hours in which to carry out checks and risk assessments. Minutes of meetings on health and safety issues were reviewed by the inspector.

The inspector observed staff abiding by best practice in infection control with regular hand-washing and the appropriate use of personal protective equipment such as gloves and aprons. Hand sanitisers and sinks were present at the entrance to the building, on the corridors and in the staff and resident areas. Latex gloves were stored safely. The inspector noted that the centre was clean and that staff maintained documentation which indicated the time and details of the cleaning regime. However, one sluice room sink required cleaning and brushes were inappropriately stored on the floor in this room. The centre had the services of an expert clinical waste disposal company. Clinical waste items were stored in an external yellow locked bin, while waiting for collection.

Hoists, wheelchairs, weighing scales, electric beds and mattresses were serviced on a regular basis and these records were seen by the inspector. Equipment for use by residents was cleaned thoroughly, on a weekly basis.

The centre was a non smoking area. Residents were informed of this prior to admission.

**Judgment:**  
Substantially Compliant

***Outcome 09: Medication Management***  
***Each resident is protected by the designated centre's policies and procedures for medication management.***

**Theme:**  
Safe care and support

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

**Findings:**  
There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The practice of checking, dispensing, and recording of medicines was in line with best practice guidelines, in the sample of residents' records reviewed. There was a single dose system in operation. Photographic identification for residents was present in residents' medication administration records. A sample of controlled drugs was checked by the inspector. The recording and storage of these drugs was found to be correct. When PRN (when required) medications were dispensed the rationale for administration was recorded on the PRN record chart. The temperature of the medication fridge was checked and recorded nightly. These records were viewed by the inspector.

Medication management was the subject of audit by the pharmacist and also by the person in charge. The GP was seen to attend the centre on the day of inspection. Since

the previous inspection the transcribing policy was generally adhered to and the transcribing nurse had signed the medication administration charts along with a second nurse. These were then signed by the GP. Medications which could be crushed were signed by the GP. Medications were reviewed three monthly. The person in charge stated that the pharmacist provided advice and documentation on various aspects of medication management for nursing staff and residents. Medication errors were recorded.

**Judgment:**  
Compliant

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

***A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.***

**Theme:**  
Safe care and support

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

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

**Findings:**

The inspector saw that notifications to HIQA were forwarded within the required timeframe. These notifications were viewed prior to and during the inspection.

The person in charge had notified HIQA of incidents and accidents in line with the requirements under Regulation 31 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Judgment:**  
Compliant

***Outcome 11: Health and Social Care Needs***

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

**Theme:**  
Effective care and support

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

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

implemented.

**Findings:**

There were arrangements in place to meet each resident's assessed needs. These were set out in individual care plans which highlighted residents' needs, interests and capabilities. These plans were drawn up with the involvement of residents and their representatives, where appropriate. The inspector saw evidence of residents' and relatives involvement and consultation. Residents were provided with the services of a GP of their choice. A review of residents' medical care was carried out four monthly. In a sample of residents' files reviewed medical notes were seen to be recorded. Wound assessment charts and skin care charts were found to be comprehensive. Residents were facilitated to attend appointments with consultants. The inspector viewed a number of relevant letters. Staff regularly checked the residents' weight, blood pressure and blood tests.

However, not all residents had their MUST (Malnutrition Universal Screening Tool) screening carried out on a monthly basis, in accordance with best practice. The person in charge outlined the assessment process for new residents. However, the inspector found that the care plan in place for one resident who required palliative care was not sufficiently detailed to guide staff in all aspects of end of life care. The person in charge undertook to expand the care plan to provide more detail into how the resident's holistic needs were to be met. Daily narrative notes were maintained for residents in a communal file. However, the inspector found that in one resident's file reviewed there was no care plan in place to correspond with recent findings documented in the narrative notes. The person in charge undertook to file daily narrative notes in the individual care plans. This would ensure that a complete person centred record of care was available and staff could promptly identify when plans of care were required. Chiropody was available and residents had access to the optician, the dentist, the speech and language therapist (SALT) and the physiotherapist, if required. The person in charge stated that physiotherapy and occupational therapy could be accessed individually where appropriate.

Dietary advice and modified diet training was provided to staff by allied health services from a nutritional company. The inspector viewed the training records of staff and found that staff had been trained in nutrition, dysphagia (swallowing difficulties) and modified diets. Staff spoken with confirmed this and were knowledgeable of specific dietary needs. There was a wholesome and varied diet available. A number of residents spoken with by the inspector stated that the food in the centre was very good. One resident said "they give us too much to eat". Non verbal residents were noted to be assisted carefully by staff and any modified dinners were seen to look appetising. A well stocked drinks and snack trolley was in use at 10.30 and again at 15.00. Residents and their representatives stated that they could access tea at any time.

There was an activity programme in place and residents informed the inspector that there were various activities available each day.

**Judgment:**

Non Compliant - Moderate

***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):**

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

**Findings:**

The centre had an up-to-date policy and procedure for the management of complaints. The complaints procedure was displayed in a prominent place and a copy was included in the resident's guide and the resident's contract of care. Residents were aware of how to make a complaint and the person in charge was the complaints officer. The provider monitored the complaints. The independent appeals person and process was outlined in the policy.

Residents and relatives spoken with by the inspector stated that they could raise any issue or concern with the person in charge or staff.

The person in charge stated there had been no complaints since the previous inspection. However, HIQA had been made aware of a complaint which was not recorded in the complaints book. The provider undertook to record all concerns and complaints raised in the centre, in the complaints book.

**Judgment:**

Non Compliant - Moderate

***Outcome 16: Residents' Rights, Dignity and Consultation***

***Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.***

**Theme:**

Person-centred care and support

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

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

**Findings:**

The centre was located near a busy town and was centrally placed in the community where residents could be apprised of local events. Residents informed the inspector about social events and parties which were facilitated in the centre. A hairdresser visited

weekly and there was a small salon on the premises. Residents were seen to have their hair done at the time of inspection. There was evidence that residents were consulted about how the centre was run, as discussed under Outcome 11: Health and social care needs.

The provider and person in charge informed the inspector that they met with residents and relatives on a daily basis. In addition, minutes of relatives' meetings were viewed by the inspector. Residents received care in a manner which respected their privacy and dignity. Residents had access to a portable phone in the centre and personal mobile phones. Televisions were located in all bedrooms and in the communal rooms.

The person in charge stated that since the previous inspection three staff members had attended activity facilitator training and this meant that there was one staff member available each day to lead the programme. The inspector spoke with one of the activity co-ordinators who was found to be enthusiastic and well suited to the role. He was knowledgeable of individual resident's likes and dislikes and stated that he also facilitated individual sessions for residents. The inspector saw the programme displayed on the notice board in the hall and observed different staff members leading and encouraging residents at music sessions and memory games. Activities included bingo, chair based exercises, quiz, art, music and planting flowers. Residents were also seen knitting, reading the paper and doing word searches. They spoke with the inspector about how they were content and happy with their lives in the nursing home. Staff, residents and family members stated that since the activity programme was enhanced residents were happier and more socially engaged. For example, the inspector sat with a new resident at tea time and noted that other residents made the resident feel at ease by engaging in conversation about their past lives, their work and their families. Residents praised the person in charge, the provider and other staff members. The inspector observed that visitors were plentiful and those with whom the inspector spoke were praiseworthy of communication in the centre.

**Judgment:**  
Compliant

***Outcome 18: Suitable Staffing***

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

**Theme:**  
Workforce

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

**Findings:**

A staff appraisal system was implemented for all staff and the inspector saw evidence of this in staff files. There was a clear management structure in the centre and staff were aware of the reporting mechanisms. Staff spoken with by the inspector demonstrated a clear understanding of their roles and responsibilities. Staff records showed that staff were recruited and inducted in accordance with best practice. During the morning of inspection the person in charge, one nurse, the administration support staff member and four care assistants were on duty. In addition, there were two catering staff and two household staff on duty. This staffing level was decreased in the afternoon and evening.

The inspector reviewed staffing rotas, staff meeting records, staffing levels and skill mix. The person in charge informed the inspector that that she was satisfied that there were sufficient staff on duty to meet the needs of residents. However, as the person in charge also worked as the nurse on duty on some days administration support had been provided since the previous inspection. The person in charge stated that this had proved to be a great support. The administration support staff undertook this role two mornings per week. The provider stated that staff had received mandatory training such as, fire training and prevention of elder abuse training. Other training issues were addressed under Outcome 7: Safeguarding and safety.

Volunteers in the centre had Garda vetting (GV) completed and had their roles and responsibilities set out.

Further staff records non compliance issues were addressed under Outcome 5: Documentation and Outcome 7: Safeguarding and Safety.

**Judgment:**

Compliant

**Closing the Visit**

At the close of the inspection a feedback meeting was held to report on the inspection findings.

**Acknowledgements**

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

***Report Compiled by:***

Mary O'Mahony  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate



### Action Plan

#### Provider's response to inspection report<sup>1</sup>

Centre name:	Strawhall Nursing Home
Centre ID:	OSV-0000295
Date of inspection:	17/10/2016
Date of response:	08/12/2016

#### 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 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:

All records required under Schedule 2 of the regulations were not maintained for staff, as outlined under this Outcome.

##### 1. 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.

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



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

The gaps in dates and references are in place since the date of inspection  
The employee in question had undertaken 6 Months work experience in Strawhall during completion of FETAC level 5 prior to commencement of employment.

**Proposed Timescale:** 08/12/2016

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

The person in charge had not ensured that staff had been afforded up to date training in the knowledge and skills, appropriate to their role, to respond to and manage behaviour that was challenging.

**2. 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:**

Behaviour that is challenging training is scheduled for all staff.

**Proposed Timescale:** 08/12/2016

**Theme:**

Safe care and support

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

Two staff members had been working in the centre for a period of time without the legally required GV in place.

Inappropriate restraint belts were in use for two residents,

One resident had his arm restrained in a manner which did not conform to best evidence based practice.

**3. 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:**

All staff have GV for our employment and this practice will continue.

Referrals have been made to the OT and guidance being sought on alternatives.

Restraint policy has been updated. Advice had been sought in the past and is ongoing re – difficulty regarding the balance between restraint and maintaining adequate dietary intake for the resident in question. The careplan also now reflects this challenge and family continue to be involved in this discussion.

**Proposed Timescale: 08/12/2016**

#### **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:**

The sluice room sinks required cleaning and brush storage was inadequate in the sluice room.

**4. 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 sluice room were deep cleaned on completion of inspection. Staff awareness of need for routine cleaning has been reiterated.  
Storage for brushes is in place.

**Proposed Timescale: 08/12/2016**

#### **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:**

Ensure that appropriate plans of care are In place to meet all the needs of residents.

For example

-for palliative care.

-for issues identified in the narrative notes which require a plan to be put in place to guide best practice.

**5. Action Required:**

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

Palliative care plans have been reviewed and developed as per guidance documents. The PIC will review the narrative notes to ensure notes are being audited and plans put place if required.

**Proposed Timescale:** 08/12/2016

### **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:**

A complaint had not been recorded in the complaint book or adequately addressed.

**6. 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:**

We have updated and discussed the complaints policy and procedure with staff and stressed the importance of documenting and investigating all complaints even if they appear minor to fully address and resolve identified complaint/concern.

**Proposed Timescale:** 08/12/2016