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## **St. Anthony's Nursing Home, Kilduff Castle, Pallasgreen, Limerick.**

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**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St. Anthony's Nursing Home
<b>Centre ID:</b>	OSV-0000428
<b>Centre address:</b>	Kilduff Castle, Pallasgreen, Limerick.
<b>Telephone number:</b>	061 384 104
<b>Email address:</b>	info@stanthonysnursinghome.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Killduff Care Co. Limited
<b>Provider Nominee:</b>	Sean Fennessy
<b>Lead inspector:</b>	Louisa Power
<b>Support inspector(s):</b>	Mary Moore
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	60
<b>Number of vacancies on the date of inspection:</b>	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 following notification of a significant incident or event. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 19 August 2015 09:05 To: 19 August 2015 20:30

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	Non Compliant - Major
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	Non Compliant - Major
Outcome 09: Medication Management	Non Compliant - Major
Outcome 10: Notification of Incidents	Non Compliant - Major
Outcome 11: Health and Social Care Needs	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Major

**Summary of findings from this inspection**

The inspection was an unannounced inspection and was triggered by a notification submitted to the Authority relating to a resident's fall and subsequent transfer to hospital. The provider nominee/person in charge had completed an investigation following the incident. The management of falls and residents' healthcare were looked into throughout the inspection and the inspectors' findings are outlined in the body of the report.

As part of the inspection process, inspectors met with the provider nominee/person in charge, director of care, residents, relatives, visitors and staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures, risk management documentation and staff records.

The centre had been extended in the past number of years, increasing the total capacity to 60 residents. A warm welcome was seen to be extended to all visitors. A programme for the provision of meaningful activity was provided for residents. A full time activities co-ordinator had recently been recruited and she had met with each resident where possible and consulted with existing staff to establish each resident's

interests, hobbies and preferences so as to inform the scope of activity that was delivered. A universally accessible vehicle was available to residents for social outings.

Of the nine outcomes examined on this inspection, major non-compliance was identified in seven and three immediate action plans were issued on the day of inspection. The immediate action plans related to the lack of assessments and care plans, inadequate supervision and provision of care to residents in line with their assessed needs and poor medicines management practices. Major non-compliance was identified in the areas of governance and management, safeguarding and safety, health and safety, medicines management, healthcare and staff supervision. Other non-compliances were identified in relation to documentation. Non-compliances are discussed in the body of the report and outlined in the action plan at the end of this report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 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:**

Inspectors saw that there had been significant investment and expansion of the centre over the last number of years. There were sufficient resources available to ensure that care is delivered in accordance with the statement of purpose.

There was evidence of a management structure. The provider nominee was also the person in charge. There were three people listed as participating in management - person in charge/provider nominee, director of care and a clinical nurse manager. The clinical nurse manager was on an extended period of leave at the time of the inspection. Inspectors observed a good and supportive working relationship between the person in charge and the director of care. The person in charge had taken responsibility for all areas of service provision. However, based on the findings from this inspection, inspectors were not satisfied that the management structure was effective with defined lines of authority and accountability. As further outlined in outcomes 11 and 18, the management and supervision systems in place had failed to identify deficiencies in the delivery of care to ensure that the service provided was consistent, safe and appropriate to residents' needs.

The provider nominee confirmed that an annual review of the quality and safety of care had not been completed. Results of audits were made available to inspectors. Regular audits were completed in three areas - medicines management, environment and health and safety. Actions emanating from these audits were limited. Due to the findings in this inspection, inspectors concluded that the audits did not identify pertinent deficiencies.

**Judgment:**

Non Compliant - Major

**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 designated centre was employed full time and was a nurse with more than three years experience in the area of nursing of the older person within the previous six years. The person in charge had worked in the centre as a nurse since 2005 and had been appointed as person in charge in 2010. He had retained a strong clinical role in the delivery of services to residents.

While speaking with inspectors, the person in charge demonstrated a comprehensive knowledge of residents and their care needs. Relatives and residents with whom inspectors spoke reported him to be visible and accessible. Inspectors observed residents and relatives to be relaxed and comfortable in his presence.

The person in charge was also the provider nominee and was therefore engaged in the governance, operational management and administration of the centre. As provider nominee, the person in charge had enhanced authority and responsibility for the provision of the service. He clearly articulated to inspectors a willingness to meet his statutory obligations and to improve the centre and quality of services provided.

**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:**

Only the components in relation to the outcomes included in this inspection were examined.

As outlined in outcomes 7 and 9, policies required review and update in accordance with the most up to date best practice.

As outlined in outcome 18, staff files were seen to be incomplete. On the day of inspection:

- evidence of Garda Síochána vetting was not available for one staff member
- two references on file were very dated and had been obtained for a purpose other than employment in the centre
- evidence of a person's identity was not on file.

**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):**

No actions were required from the previous inspection.

**Findings:**

The person in charge told inspectors that there had been no incident of alleged, suspected or reported abuse in the centre. Staff spoken with said that they had never seen or heard anything that compromised residents' rights and safety; residents spoken with said that staff were good and kind to them.

The policies in relation to the protection of vulnerable adults and responding to allegations, disclosures or suspected abuse were made available to the inspected and dated as reviewed in February 2015. However, the policies did not reference or reflect any relevant national legislation and guidance issued since 2006; this is covered in outcome 5. The policies did not provide an alternative reporting pathway for staff or the procedure for the investigation and management of any allegation of abuse where the person in charge may be the subject of the allegation.

Records made available to inspectors indicated that the policy of abuse had been

discussed with 13 staff in January 2015 and internal arrangements were in place to facilitate staff training on detecting, preventing and responding to abuse. While staff with whom inspectors spoke did articulate an understanding of what might constitute abuse on a day to day basis and their reporting responsibilities, staff confirmed that they had not all received centre-specific training as outlined in Article 8 (2).

Based on their observations, inspectors were not reassured that adequate arrangements were in place to ensure that all staff were at all times appropriately supervised to safeguard residents; this is discussed again in Outcomes 2 and 18.

Sufficient evidence was not available to inspectors to confirm that the use of restrictive devices was evidence based and a last resort. Documentation provided for inspection on the use of restrictive devices indicated that at the time of inspection restrictive devices, namely bedrails, were in use with 38 residents, (11 of whom had half a bedrail applied); 63% of the total number of residents accommodated. The rationale provided for the use of the bedrails was the prevention of falls. Alternative measures including low beds, impact reducing floor mats and a sensor alarm were in use with three residents.

A random sample of residents' records was examined by an inspector. There was inadequate completion of individualised risk-based assessments to inform and support the appropriateness and safety of the use of the bedrail, there were no care plans outlining their use and no records of their monitoring and review while in use. This was confirmed by the inspector with the person in charge. The requirement for individualised assessment, care planning, monitoring and review was clearly stated in the centres own policy on the use of restraint.

There was a policy dated as reviewed in April 2015 on the management of behaviours that had the potential to challenge staff, residents and others. Training records indicate that the following staff training had been provided in 2015:

- February 2015 – person in charge discussed the centres policy on supporting residents with dementia with 21 staff
- April 2015 – five staff had completed training on responding to behaviours that challenged.

The person in charge said that further training would be provided.

Inspectors reviewed a sample of care plans and saw that a positive approach was promoted for some residents with behaviours that challenge. A clear and proactive approach to incidents of challenging behaviour was outlined in some care plans. However, as outlined in outcome 11, many care plans had not been reviewed since 2014. A number of the care plans did not contain sufficient information to effectively guide staff in the proactive and reactive management of challenging behaviour. A list of triggers, when included in care plans, focussed on basic and generic needs such as hunger, thirst and fatigue. Therefore, personalised triggers and strategies were not in place to identify and alleviate the underlying causes.

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors reviewed the Health and Safety Statement dated 10 October 2013 and the person in charge confirmed that the statement incorporated the risk register. In that context, the requirements of Article 26 (1) (a) and (c) were not met. Four main areas of risk only were addressed - fire, manual handling, food safety and biological hazards. Measures and actions to control risks were identified for the four main areas of risk. The identification and assessment of hazards throughout the designated centre or the specified risks of abuse, the unexplained absence of a resident, accidental injury, aggression and violence and self-harm were not included. There was inadequate evidence to support the explicit identification and review of risks (both centre and resident-specific) on an ongoing basis; there was evidence that staff did not implement agreed control measures required to manage identified risk and promote resident safety. This is discussed further below and in outcome 11.

An inspector viewed a sample of electronic incident forms and saw that accidents and incidents were identified. The person in charge was informed of all incidents in a timely fashion and he completed the investigation. There was evidence of learning from some incidents and preventative actions outlined had been implemented. However, inspectors saw that mobility care plans and evidence based falls risk assessments were not always updated following a fall to ensure that all preventative actions had been identified and were in place.

A designated smoking room was provided for residents. The room was externally and mechanically ventilated, it was centrally located and viewing panels were fitted from both the main day room and the corridor. Fire detection and fire fighting equipment was in place. Residents spoken with told an inspector that controls such as restricted access to smoking materials were in place and that they were "OK" with this. However, practice was not supported by an individualised assessment of each resident's capacity and compliance, there was no plan to guide staff in relation to any identified controls required for each resident's safety such as restricted access to smoking materials, the use of the fire retardant smoking apron and the precise nature and level of staff supervision and observation. There was evidence of potential risks including burn marks on chairs, flooring and smoking aprons and a significant quantity of spent matches on the floor.

The main entrance to the centre was homely and welcoming while electronically secured by a keypad to ensure resident safety. CCTV was in use on corridors and final exits for security reasons. However, inspectors were not reassured that adequate measures were

in place to identify and protect residents at risk from leaving the centre. Some residents were identified by staff to inspectors as at risk of absconsion but inspectors saw that there was no objective assessment of risk and no care plan setting out the control measures required to protect the resident from harm and injury. Staff were inconsistent as to the number of residents at risk and did not describe clear, specific, safety interventions required to prevent the risk of a resident leaving the centre unaccompanied.

Records seen by inspectors indicated that 15% of residents had a healthcare associated infection (HCAI). There was evidence of infection prevention and control measures including single room accommodation and adherence by staff to the use of personal protective equipment (PPE) and hand-washing. Staff spoken with described the correct use, removal and disposal of PPE. However, the person in charge confirmed that recent and regular education and updates on infection prevention and control for staff were not facilitated. Inspectors observed some practices that were not consistent with standards for the prevention and control of healthcare associated infections as published by the Authority. These findings included:

- unrestricted access to high risk areas including sluice room
- inadequate facilities in sluice rooms - no hand-washing facilities in one sluice room and inadequate shelving
- inappropriate storage throughout - open topped bins including on main corridors for discarded used handtowels and PPE, towels stored on top of a toilet cistern, incontinence wear (unused) stored out of its packaging on the floor of an en-suite
- evidence of some inadequate cleaning procedures due to an unpleasant odour in an area of the centre
- the disposal of healthcare risk waste at the point of generation into bags (black bags) and receptacles that did not conform with the specifications of the relevant legislation governing the clear identification, segregation and disposal of such waste
- corroded hand-rails and grab-rails in one en-suite
- the retention of urinary drainage bags for reuse particularly when the tips of some were seen to be left exposed.

A regular environment audit was completed that included maintenance, environmental hygiene, hand hygiene and sanitary facilities. However, as outlined in outcome 2, the audit was limited in scope and failed to identify pertinent deficiencies as observed on this inspection.

Failings were identified in the arrangements in place for detecting, containing and extinguishing fires. There was evidence of investment by the provider in the upgrading of fire safety precautions. A new fully addressable fire detection system was installed and commissioned in July 2014; there was evidence of fire compartmentalisation, the installation of fire doors and the provision of automatic door holding/release devices. Escape routes were clearly indicated and fire fighting equipment was serviced in March 2015. Training records indicated that 35 staff had attended fire safety training with an external facilitator between October 2014 and March 2015 and further in-house training had been provided by the person in charge in May 2015. However, deficits were identified in the staff training programme. All staff spoken with had not attended training; the person in charge confirmed that all staff would not have attended training on the use of fire fighting equipment as outlined in the centres own fire safety policy or the procedures to be followed should the clothes of a resident catch fire.

The fire detection system had been serviced in August 2015. The person in charge said and records seen indicated that regular simulated fire evacuation drills were convened in the centre; however, the most recent record seen by inspectors was dated October 2014. Fire action and fire evacuation procedures were displayed in some locations but, given the size and layout of the centre, the number and location of these notices was not adequate to ensure that all the correct procedure to be followed was communicated to all those in the centre. Two bedroom doors were seen to be held open with door wedges; a further door wedge was seen in the smoking room but not in actual use during the inspection. One fire door with clear signage that that it was to be kept closed was held open throughout the inspection.

Staff were provided with equipment to assist them in moving and handling techniques; the equipment was marked as serviced in February 2015. Training was provided in the centre and there was documentary evidence that the trainer was suitably qualified. Training records indicated that 11 staff attended manual handling training in May 2015 and all staff spoken with said that they had attended training. However while there was evidence of narrative notes there was a deficit of risk assessments and manual handling plans for residents and one sling seen by inspectors was not clean; staff spoken with confirmed that slings were not provided to residents on an individual basis.

**Judgment:**

Non Compliant - Major

***Outcome 09: Medication Management***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

The policies and procedures for medicines management required immediate and comprehensive review to ensure that a robust and safe system was in place.

The policies in relation to medicines management were made available and reviewed by inspectors. The policies had been reviewed in February/March 2015. However, as outlined in outcome 5, the policies required review to ensure that current best practice is reflected.

Medicines for residents were supplied by a community pharmacy. Inspectors noted that the pharmacist was facilitated to meet their obligations to a resident under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. The person in charge confirmed that the pharmacist provided timely access to prescribed medicines

and was available to personally attend to residents.

The management and administration of warfarin was safe and in line with legislative requirements. The results of regular blood monitoring were maintained. Clear documentation was in place to reflect that the dose administered to the resident was in accordance with that prescribed.

Inspectors noted that medicines were not stored securely at all times. Two locked medication trolleys were used to store the majority of 'in use' medicines. Surplus stock and medicines requiring refrigeration was stored in the clinical room in unlocked cupboards and refrigerator. Access to the clinical room was restricted by a combination lock on the door. However, inspectors observed this door to be unsecured for a period of time on the day of inspection and for non-nursing staff to have unsupervised access to the clinical room and unlocked cupboards and refrigerator containing medicines.

The temperature of the refrigerator and clinical room used to store medicines was noted to be within an acceptable range during the inspection; the temperature was to be monitored and recorded daily. However, gaps were observed in the documentation; this is covered in outcome 11.

Storage of controlled drugs was safe and in accordance with current guidelines and legislation. The balance of controlled drugs was checked at the handover of shift at 08:00 and 20:00. However, the balance was not checked, as appropriate, at the handover of the afternoon shift to maintain a robust chain of custody. An inspector noted that a medicine listed under Schedule 2 in the Misuse of Drugs Regulations was signed out by a staff nurse and not witnessed at 08:20 on the day before the inspection and signed back in (without being administered) by another staff nurse and not witnessed at 11:00 on the same day. Therefore, there was a period of time where the chain of custody was not clear.

A sample of medication prescription sheets and administration records were examined by an inspector. The inspector noted that the prescription records were transcribed by a nurse with a second nurse checking the prescription transcribed. The inspector reviewed a sample of 16 prescription records and found that 68.75% had at least one spelling error. The frequency and dose of transcribed charts did not always correspond to the original record. Where amendments were made on transcribed records, these amendments were not always signed/initialled and dated to indicate the date of the amendment and who had made the amendment.

It was noted that prescriptions were not always available in order to ensure that medications were administered in accordance with the directions of the prescriber. It was observed that a prescription record that was not signed by a prescriber, transcribed from a list supplied by the resident's pharmacy on admission, was used to administer medicines for six days from admission. Prescriptions for some short term medicines were not available to those administering medicines, only a transcribed record that was not signed by a prescriber.

The maximum doses were not always stated for 'pro re nata' or PRN medicines. This included medicines where a maximum dose has been imposed by the manufacturer due

to the risk of side-effects, such as domperidone. There was no documentary record that clarification had been sought from the prescriber to ensure the correct timing, frequency and duration of the prescribed medication order.

Some residents required their medicines to be administered in a modified form. There was evidence that advice had been sought from the pharmacist and alternatives, such as liquids and soluble tablets, had been prescribed. Where medicines were to be crushed, it was prescribed individually on some prescription records observed. However, this was not consistent and inspectors noted that general authorisations to crush only contained the signature of a nurse and crushing was not individually prescribed for each medicine.

Medication administration records indicated that medicines were not given as prescribed. Analgesia, or 'painkillers', prescribed for a resident who was experiencing severe and ongoing pain were not always recorded as administered at the frequency prescribed. A medicine prescribed to be administered five times per day at specific times was recorded as being administered at different times.

A medication management audit had been completed by the pharmacist in July 2015 and the results were made available to inspectors. The audit covered documentation, controlled drugs, disposal, ordering, receipt, storage and refrigerated medicines. However, pertinent deficiencies were not identified; this is covered in outcome 2.

Staff with whom the inspector spoke outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed are stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal. However, the date of opening was not recorded on medicines with reduced expiry when opened such as insulin. Therefore, staff could not identify when this medicine would expire.

Records made available to the inspector confirmed deficits in training for staff in relation to medication management; this is covered in outcome 18.

**Judgment:**

Non Compliant - Major

***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:**

The person in charge did articulate to inspectors an awareness of his obligation to inform the Chief Inspector of incidents in line with the requirements of the Regulations. An electronic record was maintained of all incidents occurring in the centre.

However, inspectors identified notifications were not made in line with the requirements of the Regulations:

- quarterly reports did not accurately reflect all incidents where restraint was used
- two serious injuries in July/August 2015 requiring medical/hospital treatment had not been notified to the Chief Inspector
- pressure sores of grade 2 or above, including a grade 4 pressure sore, had not been notified to the Chief Inspector.

**Judgment:**

Non Compliant - Major

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

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

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of GPs were attending to the needs of the residents and an "out of hours" GP service was available if required. Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had ongoing access to allied healthcare professionals including physiotherapy, dietetics, speech and language therapy, optical, chiropody and psychiatry.

There were systems in place for the communication of resident's needs and care requirements. Staff were seen to receive a verbal handover and each staff member spoken with had an explicit record of each resident's pertinent care requirements; the person in charge confirmed that the record was updated daily as necessary by nursing staff.

The person in charge described a comprehensive procedure for the assessment of a resident's needs to be completed prior to the resident's admission in the centre.

However, documentary evidence of this assessment was not always available for review when requested by inspectors on the day of inspection.

The centre operated a computerised assessment and care planning system and the person in charge said that a new system had been introduced this year and was still in the process of completion. However, notwithstanding this, based on a random and purposeful sample of nursing records reviewed by inspectors, each resident did not have a completed comprehensive assessment of their needs, completed risk assessments as indicated, or a care plan for each area identified as requiring interventions and supports. This included areas already mentioned in this report such as infection prevention and control, restraint, and maintaining personal safety.

Where care plans were in place, some care plans had not been updated since 2014 or following a resident's change in condition, e.g. fall or return from hospital. Inspectors noted that many residents had significant and complex needs; over 50% of residents were assessed as maximum dependency. This was not always reflected in each resident's individual care plan and plans of care had not been developed in line with resident's individualised assessed needs e.g. epilepsy, psychiatric conditions and pain.

Inspectors saw that some evidence based assessment tools were used to monitor weight, falls risk and skin integrity. These tools were not used on a regular and ongoing basis to ensure that the appropriate nursing interventions were identified and that any deterioration in a resident's status would be identified in a timely manner. An appropriate assessment tool was not used to monitor and evaluate a resident's ongoing pain. Therefore, the severity of the pain and the effectiveness of the current pain management plan could not be objectively assessed.

Inspectors reviewed the electronic records relating to wound management and that care plans had been developed to guide staff in the daily care of the wound. The advice of a specialist tissue viability team was sought and integrated into the care plans. A sufficient stock of the required dressing supplies was kept in the centre. However, there was no documentary evidence of ongoing wound healing or deterioration such as dimensions of the wound or the use of photographs. Wound management charts were not maintained to describe the management of the wound including cleansing solution, treatment of surrounding skin, dressings used and frequency of dressings

Inspectors observed a dependent resident to not receive the required staff observation and assistance at mealtime. On closer inspection it was noted by inspectors that the resident based on a recent speech and language assessment required a modified consistency diet to prevent aspiration and choking. The unconsumed meal provided was not of the required consistency and consisted of three unsafe foods; this was brought to the immediate attention of the person in charge. While it was of concern to inspectors that there were failings in the assessment and care planning processes; this deviation in care where a clearly identified risk and an explicit swallow care plan that staff had knowledge of, was purposefully not implemented by staff; the person in charge confirmed this. It was of further concern that this was done in the absence of consultation with and without the knowledge of the person in charge.

There was an existing programme for the provision of meaningful activity but a full time

activities co-ordinator had recently been recruited and worked daily Monday to Friday from 11:00hrs to 19:00hrs. The co-ordinator articulated a sound understanding of the provision of activity and engagement that was person centred and meaningful. The co-ordinator told inspectors that she had met with each resident where possible and consulted with existing staff to establish each resident's interests, hobbies and preferences so as to inform the scope of activity that was delivered. Staff reported that they had direct access to a universally accessible vehicle and a group of residents had enjoyed a recent outing to a local agricultural show.

**Judgment:**

Non Compliant - Major

***Outcome 18: Suitable Staffing***

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

**Theme:**

Workforce

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

No actions were required from the previous inspection.

**Findings:**

There was a planned and actual roster in place. Based on observations, a review of the roster and these inspection findings, inspectors were assured that the staff numbers and skill-mix would be appropriate to meeting the assessed needs of the complement of residents accommodated. However, based on their own observations of care and practice, inspectors were not satisfied that adequate arrangements were in place for the supervision of staff, care and practice to ensure quality and safety at all times. During the course of this inspection inspectors were obliged to request the person in charge to immediately address matters of concern to them to ensure the dignity and safety of residents.

There was a registered nurse on duty at all times and a record is maintained of current registration details of nursing staff. Training records reviewed by inspectors indicated that, to date, in 2015 staff had completed training on medication management, behaviours that challenged, monitoring and recording vital signs, and nutrition. Staff spoken with had also undertaken education and training prior to employment that equipped them with skills and knowledge for their role.

However, records indicated and staff spoken with confirmed that all staff had not

attended mandatory training in fire safety and the protection of residents from abuse. In addition, based on these inspection findings inspectors were not satisfied that the staff training programme reflected residents' assessed needs and equipped staff with the skills and knowledge to understand and provide care that was safe and reflected contemporary, evidence based practice. The evidence to support this finding is presented throughout the body of the report in relation to medication management, the provision of modified diets, assessment and care planning, restraint, the prevention and management of falls, wound care and infection prevention and control.

A sample of staff files was reviewed and found to be incomplete; this is covered in outcome 5.

**Judgment:**

Non Compliant - Major

## Closing the Visit

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

### **Acknowledgements**

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

### ***Report Compiled by:***

Louisa Power  
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>

<b>Centre name:</b>	St. Anthony's Nursing Home
<b>Centre ID:</b>	OSV-0000428
<b>Date of inspection:</b>	19/08/2015
<b>Date of response:</b>	15/09/2015

### 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:

Management and supervision systems in place had failed to identify deficiencies in the delivery of care to ensure that the service provided was consistent, safe and appropriate to residents' needs.

#### 1. 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

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

monitored.

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

We have enlisted the assistance of external consultants to support us in the development of:

1. A clinical governance system for continuous quality improvement in the home, which will include:
  - a. Establishment of a clinical governance committee for the home.
  - b. Proactive collection of data on quality and safety indicators.
  - c. Trending and analysis of quality indicators on a monthly basis.
  - d. Development of clinical governance action plans to address issues arising from monitoring quality and safety data.
  - e. Dissemination of learning and making improvements based on monitoring of quality and safety data.
2. We will develop an audit programme for the home that will prioritise audits to be undertaken, identify learning and improvements and develop action plans at clinical governance level to disseminate learning and make improvements as identified.
3. We will develop a clinical governance policy to outline the system being implemented and to ensure that staff have the required guidance to implement the system in place.
4. As part of the clinical governance framework, we will review and improve the health and safety and risk management system, based on the international standard for risk management and the regulations (2013) which will enable us to identify hazards and risks; assess risks; develop plans to meet these risks; evaluate the effectiveness of these measures and continuously monitor risks in the home.
5. We will review and update our risk management policy to ensure it complies with the regulations and standards as well as reflect the risk management system being implemented.

**Proposed Timescale:** 30/11/2015

**Theme:**

Governance, Leadership and Management

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

Based on the findings from this inspection, inspectors were not satisfied that the management structure was effective with defined lines of authority and accountability.

**2. Action Required:**

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

We will establish and document a governance and management framework that will identify the roles, responsibilities and reporting relationships of individual staff grades. The governance and management framework will also outline the arrangements for clinical governance and risk management of the home.

**Proposed Timescale:** 30/11/2015

**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 care had not been completed.

**3. 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:**

We will undertake an annual review of the quality and safety of care to and quality of life of our residents and will include the feedback from residents in the review. Findings of the review will be linked to the clinical governance/quality improvement plan for the home.

**Proposed Timescale:** 30/09/2015

**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:**

Policies required review and update in accordance with the most up to date best practice.

**4. Action Required:**

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

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

We will revise and update our schedule 5 policies and procedures for the centre.

Proposed Timescale: Commence October 2015 and complete by December 31st 2015.

**Proposed Timescale:** 31/12/2015

**Theme:**

Governance, Leadership and Management

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

Staff files were observed not to be complete.

**5. 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:**

We will review all staff files and ensure that all of the required documentation for each file is in place.

**Proposed Timescale:** 31/10/2015

**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:**

Sufficient evidence was not available to confirm that the use of restrictive devices, including bedrails, was evidence based and a last resort:

- reasons for using bedrails were not clearly assessed or recorded
- bedrails were routinely used without risk assessments.

**6. 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:**

1. We will revise the care of residents who have bedrails to ensure that the use of the bedrails are evidence based; are used in accordance with each resident's needs and preferences and in accordance with the requirements of the National Restraint Policy (2011).
2. We will update our policy on the use of restraint to ensure staff have the necessary guidance on the requirements for use of all restraint use in the home.
3. We will provide training nursing and care to staff on the use of restraint.

Proposed Timescale:

1. October 2nd 2015.
2. October 2nd 2015.
3. October 31st 2015.

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

Not all staff had received training to manage behaviour that is challenging.

Many care plans relating to challenging behaviour did not contain sufficient information to effectively guide staff in the proactive and reactive management of challenging behaviour.

**7. 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:**

1. We will revise and update care plans for residents with challenging behaviours to ensure that they reflect the needs and wishes of residents and are underpinned by evidence based practice.
2. We will revise and update our policy for caring for residents with challenging behaviours to ensure it provides appropriate guidance to all staff caring for residents.
3. We will provide training to nursing and care staff on assessment and care planning for residents with challenging behaviours.

Proposed Timescale:

1. October 31st 2015.
2. November 15th 2015.
3. November 30th 2015.

**Proposed Timescale:** 30/11/2015

**Theme:**

Safe care and support

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

The policies did not provide an alternative reporting pathway for staff or the procedure for the investigation and management of any allegation of abuse where the person in charge may be the subject of the allegation.

**8. Action Required:**

Under Regulation 08(4) you are required to: Where the person in charge is the subject of an allegation of abuse investigate the matter, or nominate a person who is a suitable

person to investigate the matter.

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

We will revise and update our policy and procedures on prevention and responding to allegations of elder abuse to ensure that they are in compliance with regulatory requirements.

**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:**

Staff knew what to do in the event of an allegation/suspicion of abuse but not all staff had received centre-specific training.

**9. 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:**

All staff will have centre specific training in prevention and response to abuse.

Proposed Timescale: Commence September 2015 and complete by October 2015.

**Proposed Timescale:** 31/10/2015

**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:**

Routine health and safety checks and risk assessments were not being carried out and, therefore, many risks within the centre had not been identified and assessed.

**10. 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:**

1. We have arranged for a comprehensive risk assessment of the centre, including environmental and health and safety risks.

2. We will revise and update our health and safety statement to ensure it is centre specific.
3. We will revise and update the risk register for the centre to ensure that it includes environmental, occupational, clinical and resident specific risks in the home.
4. As previously outlined, we will revise and update our risk management system and policy to ensure it includes procedures for hazard identification and assessment of risks throughout the centre, including prevention and response to abuse; unexplained absence of a resident; accidental injury to residents, staff or visitors; and aggression and violence in the home and self harm.

Proposed Timescale:

1. September 30th 2015
2. October 31st 2015
3. October 31st 2015
4. October 31st 2015

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

The measures and actions in place to control the risk of abuse were not included.

**11. Action Required:**

Under Regulation 26(1)(c)(i) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.

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

1. We have arranged for a comprehensive risk assessment of the centre, including environmental and health and safety risks.
2. We will revise and update our health and safety statement to ensure it is centre specific.
3. We will revise and update the risk register for the centre to ensure that it includes environmental, occupational, clinical and resident specific risks in the home.
4. As previously outlined, we will revise and update our risk management system and policy to ensure it includes procedures for hazard identification and assessment of risks throughout the centre, including prevention and response to abuse; unexplained absence of a resident; accidental injury to residents, staff or visitors; and aggression and violence in the home and self harm.

Proposed Timescale:

1. September 30th 2015.
2. October 31st 2015
3. October 31st 2015
4. October 31st 2015

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

The measures and actions in place to control the risk of the unexplained absence of any resident were not included. Some residents were identified by staff to inspectors as at risk of absconion but inspectors saw that there was no objective assessment of risk and no care plan setting out the control measures required to protect the resident from harm and injury

**12. Action Required:**

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

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

1. We have arranged for a comprehensive risk assessment of the centre, including environmental and health and safety risks.
2. We will revise and update our health and safety statement to ensure it is centre specific.
3. We will revise and update the risk register for the centre to ensure that it includes environmental, occupational, clinical and resident specific risks in the home.
4. As previously outlined, we will revise and update our risk management system and policy to ensure it includes procedures for hazard identification and assessment of risks throughout the centre, including prevention and response to abuse; unexplained absence of a resident; accidental injury to residents, staff or visitors; and aggression and violence in the home and self harm.

Proposed Timescale:

1. September 30th 2015
2. October 31st 2015
3. October 31st 2015
4. October 31st 2015

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

The measures and actions in place to control the risk of accidental injury to residents, visitors or staff were not included

**13. Action Required:**

Under Regulation 26(1)(c)(iii) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.

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

1. We have arranged for a comprehensive risk assessment of the centre, including environmental and health and safety risks.
2. We will revise and update our health and safety statement to ensure it is centre specific.
3. We will revise and update the risk register for the centre to ensure that it includes environmental, occupational, clinical and resident specific risks in the home.
4. As previously outlined, we will revise and update our risk management system and policy to ensure it includes procedures for hazard identification and assessment of risks throughout the centre, including prevention and response to abuse; unexplained absence of a resident; accidental injury to residents, staff or visitors; and aggression and violence in the home and self harm.

Proposed Timescale:

1. September 30th 2015
2. October 31st 2015
3. October 31st 2015
4. October 31st 2015

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

The measures and actions in place to control the risk of aggression and violence.

**14. Action Required:**

Under Regulation 26(1)(c)(iv) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.

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

1. We have arranged for a comprehensive risk assessment of the centre, including environmental and health and safety risks.
2. We will revise and update our health and safety statement to ensure it is centre specific.
3. We will revise and update the risk register for the centre to ensure that it includes environmental, occupational, clinical and resident specific risks in the home.
4. As previously outlined, we will revise and update our risk management system and policy to ensure it includes procedures for hazard identification and assessment of risks

throughout the centre, including prevention and response to abuse; unexplained absence of a resident; accidental injury to residents, staff or visitors; and aggression and violence in the home and self harm.

Proposed Timescale:

1. September 30th 2015
2. October 31st 2015
3. October 31st 2015
4. October 31st 2015

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

The measures and actions in place to control the risk of the self-harm were not included

**15. Action Required:**

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

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

1. We have arranged for a comprehensive risk assessment of the centre, including environmental and health and safety risks.
2. We will revise and update our health and safety statement to ensure it is centre specific.
3. We will revise and update the risk register for the centre to ensure that it includes environmental, occupational, clinical and resident specific risks in the home.
4. As previously outlined, we will revise and update our risk management system and policy to ensure it includes procedures for hazard identification and assessment of risks throughout the centre, including prevention and response to abuse; unexplained absence of a resident; accidental injury to residents, staff or visitors; and aggression and violence in the home and self harm.

Proposed Timescale:

1. September 30th 2015
2. October 31st 2015
3. October 31st 2015
4. October 31st 2015

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

Mobility care plans and evidence based falls risk assessments were not always updated following a fall to ensure that all preventative actions had been identified and were in place.

**16. Action Required:**

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

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

1. We will review the assessments and care plans of residents who have fallen to ensure that assessments and care plans are up to date.
2. We will provide training to nursing staff on the completion of assessments and care plans for residents at risk of falling and following a fall.

Proposed Timescale:

1. October 14th 2015
2. October 31st 2015

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

Residents who smoked were not individually assessed to ensure that adequate controls were in place to control resident-specific risks. Plans were not in place to guide staff in relation to any identified controls required for each resident's safety.

**17. 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:**

We will ensure residents who smoke have a risk assessment as well as assessment and care plan to address their needs.

**Proposed Timescale:** 14/10/2015

**Theme:**

Safe care and support

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

Individualised risk assessments and plans in relation to moving and handling were not in place for all residents.

**18. Action Required:**

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

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

Individual risk assessments and care plans for all residents with manual handling needs will be developed.

**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 environment and facilities management audit was limited in scope and failed to identify pertinent deficiencies as observed on this inspection (criterion 3.8)

**19. 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:**

An audit tool for infection prevention and management will be developed and completed on a scheduled basis in accordance with the audit programme for the centre.

**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:**

Recent and regular education and updates on infection prevention and control for staff were not facilitated (criterion 4.5).

**20. 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:**

Staff will receive training on infection prevention and control.

**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:**

Inspectors observed the following which were not consistent with the standards for the prevention and control of healthcare associated infections published by the Authority:

- unrestricted access to high risk areas containing hazardous materials (criterion 3.7)
- inadequate hand hygiene facilities (criterion 6.1)
- inappropriate storage of equipment in sluice and toilets/bathrooms (criterion 3.6)
- unsuitable storage and disposal of hazardous waste (criterion 3.7)
- evidence of some inadequate cleaning procedures (criterion 3.6)
- inadequate maintenance of equipment in toilet/bathrooms (criterion 3.6)
- inappropriate management of urine drainage bags for reuse with indwelling catheters (criterion 8.1).

**21. 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:**

We have spoken to staff with regard to correct procedures for infection prevention and control.

As outlined above, we will complete an audit and provide education for staff during September.

**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:**

Training provided did not cover the procedures to be followed should the clothes of a resident catch fire.

**22. Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes,

location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

We have enlisted the assistance of an external consultant to help us with fire safety processes and training.

We will revise the fire safety training for staff to ensure that it complies with regulatory requirements.

All staff will receive updated fire safety training commencing in September 2015.

**Proposed Timescale:** 14/10/2015

**Theme:**

Safe care and support

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

A fire drill had not taken place in the centre since October 2014.

**23. Action Required:**

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

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

A fire drill will be undertaken with staff with the involvement and under the direction of the external consultant.

**Proposed Timescale:** 30/11/2015

**Theme:**

Safe care and support

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

The number and location of notices was not adequate to ensure that all the correct procedure to be followed was communicated to all those in the centre.

**24. Action Required:**

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

The number and location of notices will be reviewed and amended with the assistance of an external consultant

**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:**

Fire doors were observed to be held open by wedges.

**25. Action Required:**

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

1. All staff have been informed not to keep doors open with fire wedges.
2. Staff training on fire safety will also reiterate this.
3. A staff member will be designated to complete fire safety checks daily to include checking doors are not kept open.

Proposed Timescale:

1. September 15th 2015.
2. October 14th 2015
3. August 19th 2015.

**Proposed Timescale:** 14/10/2015

**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:**

Medication administration records indicate that medicines, including analgesia, not administered as prescribed.

**26. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

We intend to review all aspects related to medication management in the centre to ensure that they are in compliance with legislative requirements, including:

1. the prescribing and administration of analgesia to ensure it complies with the needs

of residents and legislation

2. updating our policy and procedures for medication management in the home to ensure that that staff are given direction about the requirement for all aspects of medication management

3. we will commence comprehensive auditing of medicines management on a monthly basis

4. we will amend the prescription and administration records to ensure that prescriptions include the indications for use of as required medicines; maximum dose and any additional instructions from the prescriber and pharmacist

5. we will review the current transcription procedure to identify additional safeguards required, including commencing audit of same

6. we will provide medication management training update to nursing staff

Proposed Timescale:

1. September 30th 2015.

2. October 2015.

3. October 2015.

4. October 2015.

5. October 2015.

6. October 2015.

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

Prescriptions were not always available to ensure that medicines were administered as prescribed.

**27. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

We intend to review all aspects related to medication management in the centre to ensure that they are in compliance with legislative requirements, including:

1. the prescribing and administration of analgesia to ensure it complies with the needs of residents and legislation

2. updating our policy and procedures for medication management in the home to ensure that that staff are given direction about the requirement for all aspects of medication management

3. we will commence comprehensive auditing of medicines management on a monthly basis

4. we will amend the prescription and administration records to ensure that

prescriptions include the indications for use of as required medicines; maximum dose and any additional instructions from the prescriber and pharmacist

5. we will review the current transcription procedure to identify additional safeguards required, including commencing audit of same
6. we will provide medication management training update to nursing staff

Proposed Timescale:

1. September 30th 2015.
2. October 2015.
3. October 2015.
4. October 2015.
5. October 2015.
6. October 2015.

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

The door to the clinical room was observed to be unsecured for a period of time on the day of inspection and for non-nursing staff to have unsupervised access to the clinical room and unlocked cupboards and refrigerator containing medicines.

**28. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

The door to the clinical room will be kept locked at all times when a nurse is not in the room.

**Proposed Timescale:** 15/09/2015

**Theme:**

Safe care and support

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

A robust chain of custody for controlled drugs was not maintained at all times:

- balance of controlled drugs was not checked, as appropriate, at the handover of the afternoon shift to maintain a robust chain of custody
- documentation within the controlled drugs register indicated that a robust chain of custody was not maintained when controlled drugs were signed out.

**29. Action Required:**

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

The person in charge will continue to monitor compliance with this on:

1. a daily basis
2. through audit on a monthly basis.

Proposed Timescale:

1. August 19th, 2015
2. October 31st 2015.

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

The practice of transcription was not accurate:

- significant number of transcribed records contained spelling errors
- frequency and dose of transcribed charts did not always correspond to the original record
- amendments on transcribed records were not always signed/initialled and dated.

**30. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Staff nurses have been informed that all checks must be completed in accordance with legislation.

The person in charge will continue to monitor compliance with this on:

1. a daily basis and
2. through audit on a monthly basis

Proposed Timescale:

1. August 19th 2015
2. October 31st 2015.

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

Maximum doses were not always stated for 'pro re nata' or PRN medicines

**31. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Staff nurses have been informed that all checks must be completed in accordance with legislation.

The person in charge will continue to monitor compliance with this on:

1. a daily basis and
2. through audit on a monthly basis

Proposed Timescale:

1. August 19th 2015
2. October 31st 2015.

**Proposed Timescale:** 31/10/2015

**Theme:**

Safe care and support

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

Where medications were to be administered in a modified form such as crushing, this was not always individually prescribed by the medical practitioner on the prescription chart.

**32. Action Required:**

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

We will liaise with the general practitioners to ensure that medicines to be crushed will be prescribed individually.

Proposed Timescale: August 19th 2015 and complete by September 18th 2015.

**Proposed Timescale:** 18/09/2015

**Theme:**

Safe care and support

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

The date of opening was not recorded on medicines with reduced expiry when opened such as insulin.

**33. Action Required:**

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

1. Staff will be reminded of the need to record the opening date on insulin.
2. A system of stock checking on a weekly basis will be completed.
3. Audits of medicines management will be carried out monthly by nursing staff.

Proposed Timescale: 1. August 19th 2015; 2. September 18th 2015; 3. October 31st 2015.

**Proposed Timescale:** 31/10/2015

**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:**

Notifications were not made in line with the requirements of the Regulations.

**34. Action Required:**

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

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

All notification will be sent on in accordance with requirements

**Proposed Timescale:** 19/08/2015

**Theme:**

Safe care and support

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

Notifications were not made in line with the requirements of the Regulations

**35. 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:**

All notification will be sent on in accordance with requirements

**Proposed Timescale:** 19/08/2015

**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:**

Failing to have a care plan, based on a comprehensive assessment of the resident's needs.

**36. 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:**

We will commence a comprehensive education programme for assessment and care planning for nursing staff.

Proposed Timescale: Commence October 2015 to December 2015.

**Proposed Timescale:** 31/12/2015

**Theme:**

Effective care and support

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

Pre-admission assessments were not available for each resident.

**37. 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 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:**

Pre admission assessments will be stored in the electronic system so that they are available on inspection.

**Proposed Timescale:** 19/08/2015

**Theme:**

Effective 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 a completed comprehensive assessment of their needs, completed risk assessments as indicated, or a care plan for each area identified as requiring interventions and supports.

**38. 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:**

This will be addressed as part of the education programme outlined above.

Proposed Timescale: Commence October 2015 to December 2015

**Proposed Timescale:** 31/12/2015

**Theme:**

Effective care and support

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

Some care plans had not been updated since 2014 or following a resident's change in condition, e.g. fall or return from hospital.

**39. Action Required:**

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

This will be addressed as part of the education programme outlined above.

Proposed Timescale: Commence October 2015 to December 2015

**Proposed Timescale:** 31/12/2015

**Theme:**

Effective care and support

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

Failing to provide evidence based care or arrangements to provide evidence based care to meet a resident's healthcare needs.

**40. 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:**

This will be addressed as part of the education programme outlined above.

Proposed Timescale: Commence October 2015 to December 2015

**Proposed Timescale:** 31/12/2015

**Theme:**

Effective care and support

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

Wound management documentation was not maintained in line with National Best Practice and Evidence Based Guidance for the Wound Management.

**41. 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:**

This will be addressed as part of the education programme outlined above.

Proposed Timescale: Commence October 2015 to December 2015

**Proposed Timescale:** 31/12/2015

**Outcome 18: Suitable Staffing**

**Theme:**  
Workforce

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

The staff training programme did not reflect residents' assessed needs and equipped staff with the skills and knowledge to understand and provide care that was safe and reflected contemporary, evidence based practice.

**42. 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:**

A training plan addressing the issues identified on inspection will be prepared.

Proposed Timescale: September 30th 2015.

**Proposed Timescale:** 30/09/2015

**Theme:**  
Workforce

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

Adequate arrangements were not in place for the supervision of staff, care and practice to ensure quality and safety at all times

**43. Action Required:**

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

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

A new clinical nurse manager has been appointed to replace the CNM on leave and to address supervision needs of staff.

Proposed Timescale: Completed.(15.09.2015)

**Proposed Timescale:** 15/09/2015