Report of an inspection of a Designated Centre for Older People

Name of designated centre:	St Catherine's Nursing Home
Name of provider:	Newcastle West Nursing Home Limited
Address of centre:	Bothar Buí, Newcastlewest, Limerick
Type of inspection:	Unannounced
Date of inspection:	11 & 12 April 2018
Centre ID:	OSV-0000429
Fieldwork ID:	MON-0020981

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

St Catherine's Nursing home is located in the town of Newcastle west, in Co Limerick. The building was previously a convent and has been in operation as a designated centre for over ten years. It is a two story building set in large grounds and in close proximity to all amenities in the town. Resident's private accommodation consists of 49 single bedrooms and nine twin bedrooms with en-suite facilities. Communal accommodation, such as dining and lounge facilities are located on both floors. There are three lifts allowing easy access between floors. There was an enclosed courtyard/garden area with seating for resident and relative use.

The centre is registered to provide care to 67 residents. It provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18. It is a mixed gender facility catering from low dependency to maximum dependency needs. It offers care to long-term residents and to short-term residents requiring, convalescent and respite care. Care is provided by a team of nursing and care staff covering day and night shifts. The centre employs a full time physiotherapist and physical therapist. Medical and other allied healthcare professionals provide ongoing healthcare for residents.

The following information outlines some additional data on this centre.

Current registration end date:	04/03/2020
Number of residents on the date of inspection:	62

How we inspect

To prepare for this inspection the inspector or inspectors reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
11 April 2018	10:00hrs to 18:40hrs	Caroline Connelly	Lead
12 April 2018	09:00hrs to 17:50hrs	Caroline Connelly	Lead
11 April 2018	10:00hrs to 18:00hrs	Mary Costelloe	Support
12 April 2018	09:15hrs to 17:50hrs	Mary Costelloe	Support

Views of people who use the service

Inspectors spoke with the majority of the residents present during the two days of the inspection. Residents said they felt safe and well cared for and generally knew the names of the staff looking after them. Residents were very complimentary about staff saying they were very caring and approachable.

The majority of residents reported satisfaction with the food and said they were offered three choices at meal times. They complimented the home baking which they looked forward to and enjoyed daily. Residents spoke of their privacy being protected and having choice about when they get up in the morning, retire at night and where to eat their meals. There was general approval expressed with laundry services. Clothing was marked, laundered and ironed to residents' satisfaction.

Some of the residents, with whom the inspectors spoke were complimentary about the activities and said they particularly enjoyed the music sessions, exercises and art sessions. However a number of residents said that there was not enough activities and the days could be long particularly at the weekends. Residents said they received daily newspapers and had access to televisions and radios. However residents and relatives pointed out that the sitting room upstairs was dark and did not facilitate reading. Residents confirmed that they were consulted with via residents' meetings.

Capacity and capability

Inspectors found that as identified on the previous inspection, management systems were not in place to ensure that the service provided is safe, appropriate, effective and consistently monitored. However a recent change has taken place in the ownership and directorship of the company and in the person representing the provider. The company has been bought out by one shareholder who is the new provider representative. He met with the inspectors during the inspection and demonstrated a full understanding of numerous changes that were required within the service. He had recently brought in a team of experts including a business specialist and financial controller to assist in this process. Regular board meetings were taking place, where all aspects of the service were discussed. The person in charge and ADON attended these meetings and inspectors viewed minutes of same. The management team attended the feedback meeting and gave a commitment to address the non-compliances identified as soon as possible.

The centre had a history of non-compliance identified on the previous inspections undertaken in the centre in August 2016 and September 2015. The provider and person in charge attended a meeting in the HIQA offices, following which a restrictive condition was placed on the registration of the centre in March 2017. This condition stated that as of the 27 April 2017 the registered provider will have addressed to the satisfaction of the chief inspector, the regulatory non-compliances identified in the inspection report of 08 and 09 September 2016.

On this inspection, inspectors found that although some of the non-compliances had been addressed, the majority had not been addressed. There continued to be gaps in mandatory training for staff; there was no system in place for identifying new or changing hazards; inadequate or missing risk assessments; inconsistent documentation; limited contracts for the servicing of some crucial equipment like fire alarms and emergency lighting. Other equipment servicing records were sparse and difficult to locate. There was no evidence of an effective and consistent quality assurance programme in place to continuously review and monitor the quality and safety of care. Although there was some auditing taking place these were infrequent and some assessed documentation rather than actual practices. There was no evidence of an effective quality improvement plan, therefore, in most of the audits it was difficult to assess the level of change which took place. A more systematic approach to auditing practices was needed. No annual review had been completed for 2017 prepared in consultation with residents and their families and that resulted in a copy (of the review) not being made available to residents and the chief inspector.

A new person in charge was appointed in December 2017, she had worked in the centre as a Clinical Nurse Manager (CNM) since 2014. The inspectors interacted with her throughout the inspection and an interview was undertaken. She demonstrated awareness of the standards and regulations and had commenced putting some changes in place such as the of provision of areas of mandatory training for staff, she had designed templates for a training matrix and for the induction of new staff. She had commenced appraisals for nursing staff which will also need to be rolled out to all staff. The person in charge did not have managerial training as required by the regulations, the inspectors stressed the importance of this in light of all the changes and improvements required in the centre. She told the inspectors she plans to undertake same. She was supported in her role by an Assistant Director of Nursing (ADON) and two CNM's

The management team ensured that staffing levels were reviewed on an ongoing basis so that the numbers and skill-mix were sufficient to meet the assessed needs of residents. Inspectors saw good communication between staff and residents and staff were seen to be caring and responsive to residents needs. The centre had appropriate policies on recruitment, training and vetting that described the screening and induction of new employees and also referenced job description, requirements and probation reviews. However, these had not been fully followed and implemented. A sample of staff files viewed, identified gaps in robust recruitment in that references and qualifications were not in place for all staff. One recently recruited staff member did not have a vetting disclosure in place. When the risks were identified the person in charge took the staff member off the roster until

satisfactory vetting is in place. There were also staff providing a service to the center but not directly employed by the centre who the person in charge was unsure in relation to their vetting status. The unavailability of satisfactory vetting was putting residents at risk. Although there was evidence of staff attending clinical training, the provision of mandatory training was not in place for all staff and in key areas like fire safety, moving and handling, safeguarding and responding to responsive behaviours.

Improvements were seen in the recording and management of complaints since the previous inspection. There was a comprehensive record of all accidents and incidents that took place in the centre and appropriate action taken in the review of the resident following a fall. Some incidents had not been notified to HIQA as required by the regulations. Accidents and incidents were viewed during the inspection. However the inspectors recommended further trending of accidents and incidents to identify patterns and trends so appropriate action could be taken to prevent or minimise accidents and incidents in the future.

Management of records and documentation was an issue identified by inspectors on this inspection and on previous inspections. While there was evidence that good care was provided. The frequency in which there were gaps in the record keeping and the lack of a systematic structure around this was not without risk. This aspect of the governance was brought to the attention of the provider and person in charge at previous inspections and it remained an on-going issue.

Regulation 14: Persons in charge

The person is a registered nurse with the required experience of nursing older persons and has three years experience in a managerial capacity. However the person in charge does not have a post registration managerial qualification in health or a related field as required by the regulations.

Judgment: Not compliant

Regulation 15: Staffing

During the inspection the staffing levels and skill-mix were sufficient to meet the assessed needs of residents. A review of staffing rosters showed there was a minimum of two nurses on duty at all times, with a regular pattern of rostered care staff, household and catering staff. However, some review was required to ensure staff were deployed to ensure supervision of the communal sitting rooms.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A large number of staff did not have up-to-date mandatory training.

Inspectors were not satisfied that staff were appropriately supervised, in that there was not evidence of induction programmes for new staff including probationary meetings. Although some staff had undertaken recent appraisals many had not at the time of the inspection.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents was seen to contain all the prescribed information specified in schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Overall records were not kept in such a manner as to be accessible and available for inspection as required by the regulations.

Staff files viewed by the inspectors did not contain all the requirements of schedule 2. This was also a non compliance on the previous inspection, references were missing for two recently recruited staff and a recently recruited staff member did not have Garda Síochána (police) vetting disclosure in accordance with the National Vetting Bureau Act 2012 as required by schedule 2 of the 2013 care and welfare regulations. Qualifications and records of training were also missing from staff files.

Judgment: Not compliant

Regulation 23: Governance and management

The annual review of the quality and safety of care was not completed for 2017.

There were not management systems in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors viewed a number of contracts of care and, although they did contain details of the service to be provided, the room occupied by the resident and the fee to be paid, they did not detail the charges for additional services not included in the fee.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose did not contain all the detail as specified in schedule 1 of the regulations and required updating.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Inspectors saw that there was an incident of a resident going to hospital for medical treatment following a fall and an incident of a resident absent without leave which were not reported to HIQA as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

Improvements were seen in complaints management since the previous inspection. There was evidence that complaints were recorded, investigated and actions taken. The complainant's satisfaction with the outcome of the complaint

was recorded. The procedure to follow in making a complaint was updated during the inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 policies and procedures had been updated following the previous inspection and were found to be comprehensive. However there was no policy in place for responding to emergencies in the centre and the policy on the use of Closed Circut Television CCTV required review to ensure it outlined the procedure to be followed in the centre.

Judgment: Not compliant

Quality and safety

The health care needs of the residents were well met. However the lack of effective governance systems impacted heavily on the quality and safety of the service. Improvements were required in fire safety, in all aspects of risk management and in the provision of premises and equipment that was well maintained and met the needs of the residents.

Residents' health care needs was supported by timely access to medical treatment. A number of general practitioners (GP) attended the centre on a regular basis. There was evidence that residents had access to allied health care services. This included the availability of in-house physiotherapy and physical therapy. Dietitians speech and language and tissue viability was available through a nutritional company. These therapies supported the diverse care needs of residents. There were very good links with psychiatric services and specialist nurses visited residents who required review on a regular basis. Inspectors met one of the nurses during the inspection who confirmed that behavioural and medication plans were assessed and monitored for residents who exhibited behavioural and psychological symptoms of dementia. Inspectors also observed that residents had easy access to other community care based services such as dentists and opticians. Overall, residents and relatives expressed satisfaction with the service provided.
Care delivered was based on a comprehensive nursing assessment completed on admission, involving a variety of validated tools. Care plan's were developed based on resident's assessed needs and regularly reviewed and updated. Overall, care plans were found to comprehensive and person centred. However, care plans for

residents exhibiting responsive behaviours and residents using restraint required review to ensure all staff were consistant in approach to care provided.

Inspectors found the practices around restraint use were not in line with the national restraint guidance issued by the department of health. There was a high usage of restraint in the centre with nurses informing the inspectors that nearly all residents used bedrails at night. Assessments for the use of bedrails required review and alternatives to bedrail usage were not outlined. There was no evidence of regular checks on bedrails at night and the whole practice around restraint required review.

There were not effective arrangements in place to manage risk and protect residents from harm. Inspectors identified numerous risks throughout the service and the premises that required immediate review. There were not adequate precautions in place against the risk of fire. Fire fighting equipment such as extinguishers and fire blankets were in place and serviced annually, however there was not evidence of regular checks of these and other fire safety areas in between servicing. Fire alarms and emergency lighting was not regularly checked and serviced. A fire drill had taken place in October 2017 but there was no detail of who attended, what was undertaken and what the outcomes and learning was. Many staff had not received recent fire training. During the last inspection inspectors saw numerous fire doors wedged open. Following the previous inspection a large number of fire doors were fitted with electronic controls that automatically release in the case of fire. However, on this inspection the inspectors saw a small number of fire doors wedged open with chairs and waste paper bins. The smoking room upstairs was closed for safety reasons following the previous inspection and residents who wish to smoke now use the smoking room on the ground floor. The smoking room is at the end of a corridor. The room is fitted out with smoking aprons, metal ashtrays, fire blanket, fire extinguisher and a nurse call bell. However there was no mechanical ventilation to extract the smoke and the smell of smoke was very strong and could also be smelt in other parts of the centre. The inspectors were concerned re the visability of residents who smoked. CCTV was being used as a means of supervising the residents and the camera was up high in the nurses office on the ground floor. Inspectors saw that for large parts of the day there was nobody present in the nurse's office therefore it was not an effective means of supervision.

There was no system of regular checking of the premises and equipment. Issues were responded to as they occurred rather that a proactive system of ongoing maintenance and regular checking and servicing. Many items of essential equipment did not have service contracts in place and there was no evidence of regular servicing. There was no inventory of equipment and numerous items of unused and broken equipment was left in corridors including broken garden furniture in the courtyard. The premises was not maintained in good structural and decorative repair both internally and externally. The availability and accessibility of living room and dining space required review to ensure it met the needs of all residents in the centre in a comfortable and homely manner. The living room upstairs was too small to provide seating for all residents living upstairs and even with the addition of the conservatory area it still would not provide adequate seating.

There was evidence of consultation with residents. Formal residents' meetings were facilitated chaired by the physiotherapist. Although issues discussed were very relevant, the frequency of meetings required review as one was held in March 2018 but the previous meeting was July 2017. There was also not evidence of actions taken and follow up of issues raised. The activity programme was run by the physiotherapist and physical therapist who also had a full programme of physiotherapy to provide. They usually provided activities such as exercise groups, bingo, music and cards which residents said they enjoyed. Inspectors saw long periods of time where there were no activities taking place and found that the choice of appropriate recreation and stimulating activities to meet the needs and preferences of residents was not fulfilled by this activities programme. Residents told inspectors that they would like to see more activities and a greater variety of activities including outdoor activities. Further trained staff are required to support an activity programme for the size and layout of the centre to meet the social and recreational needs of the residents.

Regulation 11: Visits

An open visiting policy was in place and residents could receive visitors in the communal areas or in their bedroom. The inspectors saw visitors in and out during the inspection who confirmed they were welcome to visit at any time.

Judgment: Compliant

Regulation 12: Personal possessions

There was plenty of storage provided in bedrooms for residents to store and maintain control over clothing and personal possessions.

Residents clothing is laundered in the centre and returned to the resident in a timely manner.

Judgment: Compliant

Regulation 17: Premises

There were a number of issues identified with the premises that did not comply with the requirements of schedule 6 of the regulations:

- the centre was not kept in a good state of repair externally and internally, there were numerous items seen by the inspectors including broken tiles, seals missing from showers, a broken radiator in the upstairs sitting room and numerous items of broken furniture left in various areas of the centre.
- the centre was not suitably decorated, paint was seen to be off the walls in many parts of the centre.
- maintenance records and contracts for the maintenance of equipment were not in place for much of the equipment.
- safe floor covering was not provided in parts of the centre and a carpet outside the smoking room was ingrained with dirt.
- communal accommodation was limited particularly upstairs where the size and layout of the sitting room was not suitable for all residents living there.
- storage in the centre was limited and many items were seen to be inappropriately and dangerously stored, blocking corridors and under stairs which could impede fire exits.
- the external grounds were not appropriately maintained and safe for use by residents. There were broken garden furniture and tables upturned in the internal courtyard which was not maintained for residents use.
- lighting and ventilation was not adequate in the upstairs sitting room. Residents had difficulty seeing out of the windows and most windows could not be opened to allow fresh air in. The room was found to be dark and stuffy and electric lighting was not sufficiently bright to enable residents to read in there. The positioning of the television did not allow access for all residents to see it.
- mechanical ventilation was also required in the smoking room.
- there was evidence of a lack of a programme of regular checks and on-going maintenance
- there was no inventory of equipment

Judgment: Not compliant

Regulation 26: Risk management

Inspectors found there were inadequate systems in place to monitor and review risks.

- the risk register was not regularly reviewed and many risk assessments had not been updated since 2014
- there were inadequate risk assessments in place
- a number of windows were seen to be without restrictors, including a window in the dining room upstairs, this was secured following identification of same to the provider.
- there was unsecured access to sluice rooms and the laundry room
- there was unsecured access to stairwells and a lack of risk assessments and control measures
- there was no emergency plan in place to guide staff in the event of any emergency situation

Judgment: Not compliant

Regulation 27: Infection control

Staff were knowlegable in relation to infection control. Inspectors observed staff abiding by good practice in hand hygiene and training had been provided in infection control. However, clinical and medical equipment were seen to be stored in sluice rooms such as nebulisers, nebuliser masks, hoist slings, peg feeding stands which is totally contrary to infection prevention and control policy guidance.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors were not satisfied that there were adequate arrangements in place to protect against the risk of fire.

- there was no servicing records available for the fire alarm or emergency lighting. A service contract was put in place recently.
- annual fire training was out of date for most staff
- the frequency and recording of fire evacuation drills required review
- some fire doors were seen to be wedged open with bins, chairs
- regular fire checks on means of escape, fire alarm, automatic door release, monthly check on extinguishers were not taking place.
- the location and supervision of the smoking room required review.
- storage of furniture and equipment at the top of stairs and under stairwells is a fire hazzard.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were seen in medication management since the last inspection. There were written operational policies and procedures in place on the management of medications in the centre. Medications requiring special control measures were stored appropriately and counted at the end of each shift by two registered nurses. A sample of prescription and administration records viewed by the inspectors contained appropriate identifying information. Medications requiring refrigeration were stored in a fridge and the temperature was monitored and recorded daily.

Medications that required crushing had an instruction at the bottom of the residents prescription sheet saying the resident may have their medications crushed or capsule opened. However medications were not individually prescribed as such and some medications cannot be crushed, therefore nurses may be administering medications in an altered format without the appropriate prescription which could lead to errors.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvements were seen in the overall assessments and care planning since the previous inspection. Care plans viewed by inspectors were personalised, regularly reviewed and updated following assessments completed using validated tools. End of life care plans were in place and detailed residents wishes at end stage of life. Improvements were required in care plans for residents exhibiting responsive behaviours and for residents using restraints

Judgment: Substantially compliant

Regulation 6: Health care

Inspectors were satisfied that the health care needs of residents were met. There was evidence of regular access to medical staff with regular medical reviews in residents files. Access to allied health was evidenced by regular reviews by the physiotherapist, dietician, speech and language, chiropodist and psychiatry of old age as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of restraint in the centre required review to ensure it is only used in accordance with the national policy as published on the department of health website.

Judgment: Not compliant

Regulation 8: Protection

Residents reported to feeling safe in the centre and staff were aware of what to do if there was an allegation of abuse. However, safeguarding training was not up to date for staff the action for this is under staff training.

Improvements were seen in the management of residents' finances and a more robust system was implemented.

Judgment: Compliant

Regulation 9: Residents' rights

Facilities for occupation and recreation required review, the activity programme was limited in the amount and type of activities provided and inspectors were not satisfied that these were provided in accordance with the residents interests and capabilities.

There was some evidence of residents' rights and choices being upheld and respected. Residents were consulted with via residents' meetings, however the frequency of these meetings required review and there was not documentary evidence of the follow up and actions taken as a result of issues raised.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Catherine's Nursing Home OSV-0000429

Inspection ID: MON-0020981

Date of inspection: 11/04/2018 and 12/04/2018

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:

- The person is charge has a post graduate course in Rehabilitation of Older Care and engages in professional development on a regular basis most recently completing venepuncture and a wound care course.
- The person in charge has enrolled in a key management skills and service quality course due to commence in June 2018. Further courses will be identified for commencement in September.
- The directors and financial controller with their management experience will support the PIC.
- The promoter has developed a discussion forum with another nursing home.

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

- It is the intention to maintain the current levels of staffing, in particular nurses and carers.
- It was identified in the audit that inadequate activities were planned and undertaken for patients. To address this, the role of activities co-coordinator has been advertised and currently the applicants are being vetted. Interviews will be carried out by the Person in Charge and director.
- The co-ordinate will commence on August 1st.
- Regular planned activities will be scheduled and commence in August 1st.
- Input from patients and families will be solicited for this plan.
- Activities that will be input into this plan, depending on patient's interest, will be baking, art and crafts, gardening, flower arrangement, coffee mornings, men's shed, beauty therapy,quizzes,card games, bingo, sensory activities (touch, feel, smell)sowing, crochet, knitting, music and day trips etc.
- Activities in certain cases will need to be dementia specific, reminiscence therapy, relearning, and reality orientation therapy.

- Dayroom supervision will be logged with the name and time a staff member is in the dayroom. This log will be our control to ensure dayrooms are not unsupervised for extended periods of time.
- A new resident's roll call has been implemented in May 2018 as an additional measure to supervise more appropriately. It is a logged every 2 hours. It is the nurse's responsibility to complete.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- A new induction booklet was introduced in April 2018 and completed for all recent hires over the past 8 months. This induction booklet encompasses Health & Safety, procedures, policies, fire, and evacuation. All new staff now undergo a 2 week induction period, copy of booklet attached.
- Each new hire are aligned with an existing member of staff for mentoring, as in a "buddy" system for a two week period.
- Appraisals have been reviewed and divided amongst all persons participating in management. Currently there has been 37 appraisals completed and 42 outstanding, balance of 8 staff are new. All appraisals will be completed by October.
- A new detailed matrix for staff training has been developed and will be reviewed on a monthly basis and training allocated accordingly. Outstanding training to be completed by the end of October 2018. A copy of the training matrix is attached to this document.
- The centre has become a member of an organisation which will assist in further development of training.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

- All staff have been Garda vetted, those outside the 3 year window have been resubmitted for Garda vetting.
- Anyone who is not Garda vetted will not be allowed work on the premises.
- The directors and external management team are currently being Garda vetted.
- Outstanding documentation for current staff have been identified (copy attached)
- This will be completed by September (due to holiday period)
- A central matrix and log will be maintained at the administration desk.
- Access to records on a timely basis will be achieved in a central location or Vcare implemented.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The person in charge is new to the role since December 2017 and unable to complete an annual quality review report for 2017. An annual quality review report will be submitted in Dec 2018 by the registered provider.

2 weekly board management meetings will be held with a structured agenda to review and monitor all aspects of the centre.
The provider will attend the center frequently in addition to the meetings.
By June 30th a detailed governance and management plan will be submitted.

VCare to be introduced in September 2018.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

- All contracts of care have been updated for services and any additional charges.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

- Statement of Purpose reviewed at Board of Management meeting in accordance with schedule 1 and now complete.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

- The HIQA portal will be used for communications (numerous emails, conversations with HIQA with difficulty to access system currently) and as requested on forms posted in addition. Quarterly returns, notification of incidents (including slips or falls), etc. will be completed as required.
- The Board of Management will review safety incident log book and discuss with staff any incidents to ensure that they have been reported, investigated and corrective actions taken.

- Since the inspection 3 NF03,2 NF06

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

- New policy for the management of internal emergencies and evacuation including fire are now in place.
- The fire control panel has been serviced and a maintenance contract put in place.
- Emergency lighting has been repaired on the ground floor, second floor currently being upgraded (final certification in September)and a test programme put in place
- CCTV policy and procedure currently being updated in accordance with new GDPR legislation. To be completed at the end of July 2018
- All written policies and procedures will completed and fully implemented by November 2018. Currently there are 153 policies and procedures written and 30 to be completed.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises
The following actions have been undertaken and completed

- All broken furniture and unused items have been removed from the centre following inspection.
- Broken radiator repaired.
- Painting completed at entrance, reception, main corridor, corridor on the first floor. Painting completed as required throughout the rest of the building.
- All skirting boards have been cleaned.
- The curtains in dayroom removed.
- A corrective plan has been completed and agreed for the showers. Work has commenced and is planned to be completed by July 31st (67 in total)
- The carpet has been removed and replaced outside the smoking room (April 2018).
- An extractor for the smoking room has been purchased and will be installed on June 20th
- Included in the care plan are patients (5) who smoke, patients who are identified as a high risk (1) from a slip, trip or fire will be accompanied by a carer who places the patient next to the call bell and applies the fire retardant apron. The carer will accompany the patient back. The smoking room is monitored by CCTV.
- The upstairs dayroom has been identified as requiring additional lighting. We cannot modify the existing windows as they are a part of a listed building requirement. Additional electrical lighting or enhanced lighting will be installed in this dayroom by July 31st. The location of the current TV will be reviewed and additional TV's will be supplied to ensure all patients have clear visibility.
- All windows will be fitted with restrictors by July 15th
- Door stoppers have been fitted to all bedroom doors.

- Suitable storage facilities onsite and offsite have been put in place.
- A facilities maintenance programme will be developed by August 1st

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
Risk management assessment for each area, with their current status, are outlined below;

- Hazard identification– to be finally completed by Nov 30th
- Fire – upgrade to policy to be completed by June 30th.
- Slips and falls – to be completed August 31st
- Sharp/Needle stick injury –to be completed August 31st
- Abuse –to be completed by July 10th
- Absconsion –to be completed by July 10th
- Accidental injury to residents, visitors or staff
- Agression, violence to be completed June 30th
- Self harm - to be completed October 31st
- Essential services – to be completed September 30th

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The following actions have been undertaken;
- All unnecessary equipment in sluice rooms have been removed.
- All unused equipment throughout the center have been removed
- Daily inspections will be undertaken by the Promoter, PIC or a designated person.
- Training matrix plan developed on infection control for all staff (copy attached)
- 56 staff pf 65% of all staff have undertaken infection control training.
- Training scheduled for July 11 and 18,September 10,19 and 28

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The following actions have been completed;
- Fire alarm control panel serviced.
- Emergency lighting has been repaired on the ground floor, second floor currently being upgraded (final certification in September)and a test programme put in place
- Maintenance contracts put in place for control panel and emergency lighting.

- Fire drill completed
- Plan for regular fire drills developed.
- A staff member has been trained as a fire training instructor.
- A permanent fire officer with Limerick FD, will audit and report on a monthly basis.(we will be guided by his recommendations on frequency)
- 35 fire evacuation blankets have been purchased recently. The centre now has 67.
- Excess furniture and equipment has been removed.
- All door stops fitted and linked to the fire control panel.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

The following actions have been undertaken;

- The pharmacist, is amending the documentation of administrating medication. To be completed July 30th
- Breaking pills is not done in the center.
- Pharmacist will write the amount eg.12.5 mg instead of 50% of a tablet
- All medicine that requires crushing is currently signed by the GP. Each individual drug that requires crushing will be signed by the GP

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

- An assessment of patients for responsive behaviors has been completed.
- A new care plan for 12 patients (all from assessment) has been developed and implemented.
- An audit of restrictive practices, who is using them,
  Will be completed by 30th June.
- Assessment of new patients will be completed before admission.
- Restraint training will be developed August 31st

Regulation 7: Managing behavior that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behavior that is challenging:

- An assessment of patients currently using bedrails / restraints will be completed

by 30th June.

- As part of the care plan this will be assessed at an individual level every three months.
- Training for challenging behavior is included in the training matrix.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The following actions will be completed;

- Quarterly residents meetings, minuted and distributed.
- Suggestion box
- Bi-annual patient and family survey
- Activities co-ordinator in place August 1st.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(6)(b)	A person who is employed to be a person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a post registration management qualification in health or a related field.	Not Compliant	Orange	September 2018
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	August 2018
Regulation 16(1)(a)	The person in charge shall	Not Compliant	Orange	October 2018

	ensure that staff have access to appropriate training.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	October 2018
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	December 2018
Regulation 21(1)	The registered provider shall 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.	Not Compliant	Orange	September 2018
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	September 2018
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	December 2018

Regulation 23(d)	The registered provider shall ensure that 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.	Not Compliant	Orange	December 2018
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	April 2018
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.	Not Compliant	Orange	November 2018
Regulation 27	The registered provider shall	Not Compliant	Orange	September 2018

	ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	September2018
Regulation 28(1)(d)	The registered provider shall 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.	Not Compliant	Orange	September 2018

Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	September 2018
Regulation 29(5)	The person in charge shall 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.	Substantially Compliant	Yellow	July 2018
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	May 2018
Regulation 31(1)	Where an incident set out in paragraphs 7 (1)	Not Compliant	Orange	May 2018

	(a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	November 2018
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	June 2018
Regulation 7(3)	The registered provider shall 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.	Not Compliant	Orange	July 2018
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Not Compliant	Orange	August 2018

	activities in accordance with their interests and capacities.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Yellow	August 2018