Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Mystical Rose Private Nursing Home
Centre ID:	OSV-0000367
Centre address:	Knockdoemore, Claregalway, Galway.
Telephone number:	091 798 908
Email address:	info@mysticalrose.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mystical Rose Limited
Provider Nominee:	Eileen McLoughlin
Lead inspector:	Mary McCann
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	54
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
17 November 2016 09:30	17 November 2016 18:30
18 November 2016 09:00	18 November 2016 14:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report set out the findings of an unannounced monitoring inspection. This inspection took place over two days. As part of the inspection, the inspector met with residents, relatives and staff members and observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.
Notifications of incidents received since the last inspection were reviewed pre this inspection and reviewed and discussed with staff during this inspection.

Mystical Rose Nursing Home is registered with the Health Information and Quality Authority to provide care and support for up to 54 residents. There were no vacancies at the time of this inspection. The centre was clean, warm and well decorated with a calm pleasant atmosphere. There was an adequate complement of staff with the required skills on each shift. There was a good variety of communal areas which provided sufficient space for residents to meet their personal, social and

recreational need. The provider who also fulfils the role of the person in charge (referred to throughout this report as the provider) was available throughout the inspection. She was knowledgeable of the regulatory requirements and verbalised a commitment to providing quality, person-centred care.

Discussions between the inspector, residents and relatives confirmed that residents were listened to, valued and communicated with in an appropriate manner
Relatives spoken with confirmed that a warm welcome was extended to them by all staff. They advised that they felt confident that if they raised a concern or query with any staff, their concern would be addressed appropriately.

Observations throughout the inspection evidenced that there was a calm atmosphere in the centre and staff interactions with residents were observed to be compassionate, caring and timely. Residents were observed to be sitting in the lounges, dining room or in their bedroom as was their personal preference. A number of opportunities were observed when staff took time to find out what the resident wanted when it was not always apparent as some residents were not able to express their needs and wishes verbally. Staff were observed responding to residents' needs respectfully and cheerfully and took time to offer and provide reassurance as was required from time to time. Staff spoken with were knowledgeable regarding residents' likes and dislikes and had a good knowledge of residents ' life stories which they used to engage with them.

Residents and relatives spoken with expressed their confidence in raising concerns with the staff/ management and comments received were very complimentary. Residents and their relatives confirmed that the provider and the assistant director of nursing were visible and available to them on a daily basis.
Resident's personal appearances were presented to a good standard and there was evidence of staff's attention to detail, for example ladies wore neck scarfs to accessorize their clothing and staff styled residents hair regularly. Resident's healthcare needs were being met and staff described good access to general practitioners (GP) and allied health professionals.

A total of 12 Outcomes were inspected. seven outcomes were found to be compliant with the regulations, four were substantially compliant and one was moderately non complaint, this related to the premises. Areas which require review include, separating the sluice room from the laundry, fire drill practices require review to ensure simulated fire drills are undertaken to reflect a night time situation when staffing levels are the lowest, care plans require review to ensure they are more person centred and positive behaviour support plans need to be enacted for residenst with responsive support

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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:
There was a defined management structure in place to ensure the effective governance of the service. Governance arrangements were in place to ensure the service provided is safe, appropriate and consistent. The provider worked full-time in the centre and had recruited suitability skilled senior clinical and administration staff to support her. Adequate resources were available to ensure adequate staffing and appropriate assistive equipment to meet the needs of residents was available. Arrangements are in place for staff to access support out of hours and to support staff (e.g. staff meetings, appraisal and supervision). Staff confirmed that there are good working relationships within the centre and that management are responsive to suggestions or concerns raised.

The inspector found that the quality of care and experience of the residents was monitored and assessed on an ongoing basis. The provider and staff worked together to address the needs of residents. There are procedures to facilitate audit, including clinical audit such as falls audit, wound audit, nutritional audits and resident satisfaction surveys. Results of audits were analysed and actions identified for improvement were adapted into practice.

Audits of incidents are undertaken, trends and patterns identified and learning, outcomes are identified and disseminated to staff. Staff told the inspector that the provider was supportive of ensuring continuous improvement and gave the autonomy and authority to staff to implement change in accordance with the findings of audits. However, under regulation 23(d) the registered provider shall ensure that that an annual review of the quality and safety of care delivered to residents in the designated centre is carried out .This review must be carried out in consultation with residents and their families. No annual review of the quality and safety of care delivered to residents had been completed.

Judgment:
Substantially Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
There has been no change to the role of person in charge since the previous inspection. The provider holds a joint role of provider/person in charge. She has been the person in charge since the commencement of the regulation process and has the experience and knowledge to comply with Regulation 14. She demonstrated that she had a good knowledge of the Regulations and Standards pertaining to designated centres.

The person in charge confirmed that she had up to date safeguarding training, safe moving and handling training and fire safety training. Her registration with an Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland) (ABA) was in date. She had maintained continuous professional development in areas including medication management, assessing need, dementia care, assess, care planning and pressure ulcer prevention. She was well known to residents, relatives and staff. Throughout the inspection process she ensured that any information requested was immediately made available and expressed the view that she welcomed the inspection process and seen it as an opportunity to improve and develop a well run person centred service that she and her staff could be proud of. She showed a genuine interest in ensuring that the service was well run and at the heart of the service was positive outcomes for residents.

Judgment:
Compliant

Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
The inspector found that there were systems in place to maintain complete and accurate records. Documentation was found to be complete and well organised which supported ease of access to information. Records relating to residents and staff were maintained in a secure manner to protect confidentiality.

All of the written operational policies as required by Schedule 5 of the Regulations were in place.

The directory of residents met the requirements of the regulations. A sample of seven staff files to include the files of the most recently recruited staff, the provider and the persons participating in the management of the service were reviewed. The files were examined to assess if all documentation as detailed in Schedule 2 of the regulations was available. The inspector found that all files reviewed were in compliance with Schedule 2.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
Appropriate arrangements were in place for the management of the centre in the absence of the person in charge. The assistant director of nursing who has experience of working in elderly care and works full-time deputised in the absence of the person in charge. She is a registered nurse having qualified in 1999. She has worked continuously in elderly care since 2009 and has worked in the centre since May 2015. Her registration with An Bord Altranais was up to date. She displayed a good knowledge of residents and was observed to relate well with staff and residents.

Judgment:
Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
Measures were in place to safeguard residents. Staff spoken with was knowledgeable about and had a good understanding of safeguarding. Policies and procedures were in place to include the definitions of abuse, types and indicators of abuse. Information in policies guided staff as to the onward referral arrangements including contact information. A template form for referral was available. All staff had undertaken training in safeguarding, refresher training is provided as required.

The provider confirmed that all staff had Garda vetting in place. A visitor's book was maintained and all visitors were required to sign in and out of the centre. The entrance was secure and required a key pad code to open the doors. Residents spoken with stated they felt safe and secure in the centre.

There was a policy on the management of responsive behaviours. At the time of inspection there were a small number of residents who presented with responsive behaviours. However, a positive behaviour support plan with a person centred reactive strategy was not in place to ensure a consistent approach when working with residents with responsive behaviour. Staff informed inspectors how they manage the behaviour and the distraction techniques they utilise. Observations of how staff manages residents presenting with responsive behaviour showed that staff responded appropriately to residents and allayed their anxiety and distress. There was good evidence of access to psychiatry of later life.

A policy was available on the use of restraint in the centre. Twenty three residents had bedrails in place and one lap belt was in use. Evidence of alternatives considered or trialled was available. In discussion with the assistant director of nursing on the use of bedrails she described how most were used as an enabling function and were in place for the purpose of positioning or enhancing the residents' function. However care plans were not in place detailing the rationale for use of bed rails. The lap belt in use was used as a safety measure to transport the resident safely. Records indicated that restraint was only used following a risk assessment.

Judgment:

Substantially Compliant

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:
There were procedures to undertake and record internal fire safety checks. Daily fire exit checks and weekly fire alarm testing was undertaken. The fire extinguishers were checked to ensure they were in place and intact, the fire panel and automatic door closers were also checked to ensure they were operational. There was an ongoing programme of refresher training in fire safety evacuation. This was facilitated by an external trainer.

However, fire drill records were not comprehensively completed and did not record the scenario undertaken, the time taken to respond to the alarm, to discover the location of the fire and safely respond to the simulated scenario, what time it took to evacuate and whether there were any impediments to safe swift evacuation. No review of learning from fire drills had occurred to inform staff what worked well or identify any improvements required. No fire drill had been completed simulating a night duty scenario when the least amount of staff is on duty.

Service records reviewed confirmed that the emergency lighting and fire alarm system were serviced regularly. The fire extinguisher equipment had been serviced in January 2016. On walking around the centre the inspector noted that fire exits, were unobstructed. Ski evacuation sheets were in place for all residents who were immobile. beds. Review of the fire training records showed that all staff had undertaken training in fire safety. This was confirmed by staff. All staff spoken with knew what to do in the event of a fire. Fire evacuation notices were in place throughout the centre.

An up-to-date safety statement was in place. The risk management policy required review as it did not meet the requirements of the regulations. For example it failed to reference polices regarding abuse, missing persons and other aspects of regulation 26. A comprehensive risk register was in place detailing controls in place to mitigate the risk.

Training was provided to staff in the safe movement and handling of residents. There was safe floor covering and handrails throughout the centre. Specific equipment for residents' use such as specialised chairs and safe hoists were available. Records confirmed these were regularly serviced.

There was access to supplies of gloves and staff was observed using the alcohol hand

gels which were available throughout the centre. There was a policy in place for the prevention and control of infection but the location of the sluiceroom in the laundry posed a risk of cross infection.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
Nursing staff had completed medication management training. The inspector observed one of the nursing staff on part of their medication round and found that medication was administered in accordance with the policy and An Bord Altranais agus Cnáimhseachais Na hÉireann (Nursing and Midwifery Board of Ireland) guidelines. There were operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Audits in conjunction with the pharmacist were being completed.

Medication was reviewed by the residents' general practitioner regularly. The prescription sheet included the appropriate information such as the resident's name and address, any allergies, and a photo of the resident. The General Practitioner's signature was present for all medication prescribed and for discontinued medication. Maximum does of PRN (as required medication) was recorded.

Medications that required strict control measures (MDAs) were managed in line with professional guidelines. The stock balance was checked and signed at the change of each shift, and signed by two nurses. There was evidence of good support from pharmacy services that provided training to staff, auditing of medication practices and daily deliveries as required.

Judgment:
Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
The inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre.

All notifications including a nil return had been submitted to HIQA as required.

Judgment:
Compliant

Outcome 11: Health and Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident's assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
A range of validated risk assessments which were completed as part of the admission process which were used in some instances to inform the care plan. Care records accurately reflected that, where appropriate, referrals were made to other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians and any recommendations made were adhered to.

Aspects of the care planning documentation required improvement to reflect a more person centred approach with consultation from residents and where appropriate relatives. However, staff could clearly describe person centred care and how this was delivered to residents. Supplementary care charts such as food and fluid intake records evidenced that records were in the majority maintained in accordance with best practice guidance, however, some were poorly completed and not totalled accurately at the end of the day thereby decreasing their therapeutic value. In some charts reviewed, staff when recording were not always detailing the type or volume of fluids taken.

One resident had a pressure wound at the time of inspection. There was evidence available that this had almost resolved. The care plan for this wound required review to ensure it was person centred and reflected the type of dressing and linked the care plan

to nutritional care.

Judgment:
Substantially Compliant

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Effective care and support

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

Findings:
Requirements documented at previous inspections, pertaining to infection control and the environment had not been actioned. The sluice room was inappropriately fitted in the laundry room which increased the risk of cross infection. These actions have been documented in previous reports with a timeline of completion for 31 July 2015, however they had not been addressed. Additionally regarding the premises, there were no separate toilets provided near to the day rooms on the first floor and as a result all residents using the dayrooms had to return to their bedrooms to use the bathroom. There was also no fitted bath provided consequently residents did not have a choice of having a bath (a portable bath is available). These actions have been documented in previous reports with a timeline of completion for 31 July 2015, however they had not been addressed.

Mystical Rose is a 54 bedded nursing home located on the N17 approximately 1 mile north of Claregalway. The main entrance is located to the front of the building. Accommodation on the ground floor consists of a reception area, a number of day-rooms, a visitor's room, oratory and dining room. Single and twin rooms with en suite toilet and assisted shower facilities are available to accommodate 33 residents. Two additional communal toilets are located adjacent to the day rooms.

On the first floor there are two day rooms. Single and twin rooms with en suite toilet and assisted shower facilities are available to accommodate 21 residents. Four staircases and a lift are provided between the ground and first floor. This is to ensure safe evacuation by way of stairs. An enclosed garden with suitable garden furniture and raised beds is available on the ground floor. The entrance is wheelchair accessible and there is ample car parking available to the front and sides of the building for residents, visitors and staff. Residents' bedrooms were personalised clean and well furnished with

photographs, pictures and personal items. The premises were well maintained and decorated and furnished to a high standard providing a pleasant home for residents. Call bells were readily accessible to residents.

Judgment:
Non Compliant - Moderate

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:
Person-centred care and support

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

Findings:
The inspector found that there were care practices and facilities in place so that residents received end-of-life care in a way that met their individual needs and wishes. Inspectors also saw that residents' dignity and autonomy were respected. Having reviewed a sample of care plans the inspector was satisfied that each resident or their relative had been given the opportunity to outline their wishes regarding end of life. An end of life care policy was in place. Staff confirmed that the centre received support from the local palliative care team if required.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
The provider/person in charge worked full time and was actively engaged in the governance of the centre. The provider had recruited an assistant director of nursing in May 2015. This strengthened the clinical governance in the centre.The inspector viewed the staff rota and observed staffing levels over the two days of the inspection. The provider confirmed that staffing levels and the skill mix were reviewed regularly and adjusted in response to residents' needs. The person in charge and staff spoken with demonstrated their knowledge, skills and experience necessary to fulfil their role and responsibilities regarding care of older persons.

There were 20 residents who had maximum dependency needs, 13 who had high dependency needs, 17 who had medium dependency needs and 14 who were assessed as low dependency. The inspector reviewed duties rotas over a three week period and found they demonstrated that there were sufficient numbers of staff to meet the needs of residents. All residents and staff spoken with expressed no concerns with regard to staffing levels. Staff were available to assist residents and residents were supervised at all times.

The inspector saw that there were two nurses on duty at all times, one based on each floor. The assistant director of nursing and the provider were supernumerary. There were nine health care assistants rostered to care for residents up until 12 midday and six in the afternoon, four in the early evening and this increased to six after 16:30. Additionally, two activities coordinators were employed from 9:30 to 16:30 seven days per week and a physiotherapist worked two days per week in the centre. There were four care assistants and two staff nurses on duty from 20:00hrs to 21:30. there were two care assistants and two staff nurses on duty from 21:30 to 08:00. The inspector noted that all communal areas were supervised at all times. While documentation as discussed under outcome 11 required review to ensure it was more person centre staff knew residents very well and many residents had lived in the centre for considerable periods of time. Staff were observed to interact with the residents in a caring, patient and respectful manner. Staff on duty said they had sufficient time to perform their duties.

The provider confirmed that there was a low turnover of staff. Appropriate recruitment procedures were evident. The registration numbers for nursing staff with an Bord Altranais agus Cnáimhseachais na hÉireann were available for all staff nurses. There was a training matrix available to ensure that mandatory training requirements were met. A review of training records showed that all staff had up to date mandatory training in place. When new staff were employed they completed an induction programme which includes mandatory training in safeguarding residents, safe moving and handling and fire safety training.

A discussion with the assistant director of nursing advised that staff responded very positively to the provision of training and that management were supportive in ensuring that staff met their training requirements. When new staff were employed they completed an induction programme which includes mandatory training in safeguarding residents, safe moving and handling and fire safety training.

A system was in place to ensure staff receive regular supervision and an annual

appraisal was carried out with each staff member. A recently recruited senior nurse completed competency and capability assessments for staff on various areas such as knowledge of safeguarding, interaction and observation of delivery of care to residents. There was a policy on confidentiality and staff signed a confidentiality agreement prior to commencement of work.

Judgment:
Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary McCann
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	Mystical Rose Private Nursing Home
Centre ID:	OSV-0000367
Date of inspection:	17/11/2016
Date of response:	28/12/2016

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No annual review of the quality and safety of care delivered to residents had been completed.

1. 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

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

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:
Collection of Data for Annual review for 2016 has commenced. This full annual review of the quality and safety of care delivered to our residents will measure our performance against the national standards and identify areas for the ongoing improvement of our service. The annual review will made available in a user friendly format to our residents.

Proposed Timescale: 17/02/2017

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A positive behaviour support plan with a person centred reactive strategy was not in place to ensure a consistent approach when working with residents with responsive behaviour

2. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
A positive behaviour support plan with a person centred reactive strategy is ongoing at present. Some care plans were completed at the time of inspection and we hope to have this fully completed by the end of January. Staff will have up to date knowledge and skills, appropriate to their role, to ensure a consistent approach when working with residents with responsive behaviour.

To date 85% of nursing and care staff have completed training in dealing with behaviours that challenge within the last eighteen months. Outstanding staff have been given a time frame to have this completed.

We have rolled out care planning training to all nursing staff following inspection and to date 50% have completed this training.

Proposed Timescale: 31/01/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy required review as it did not meet the requirements of the regulations. For example it failed to reference polices regarding abuse, missing persons and other aspects of regulation 26.

3. Action Required:
Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

Please state the actions you have taken or are planning to take:
The risk management policy is in the process of being reviewed to include reference to polices regarding abuse, missing persons and to include all requirements of Regulation 26(1)

Proposed Timescale: 31/01/2017

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:
Aspects of the care planning documentation required improvement to reflect a more person centred approach with consultation from residents and where appropriate relatives.

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

Please state the actions you have taken or are planning to take:
We have rolled out care planning training to all nursing staff following inspection and to date 50% have completed this training. All care plans going forward will reflect a more person centred approach with consultation from residents and where appropriate relatives. This will continue to be audited and the audit will ensure resident and where appropriate relatives input.

Proposed Timescale: 03/03/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Requirements documented at previous inspections, pertaining to infection control and the environment had not been actioned. These actions have been documented in previous reports with a timeline of completion for 31 July 2015, however they had not been addressed.

The sluice room was inappropriately located in the laundry room which increased the risk of cross infection.

There were no separate toilets provided near to the day rooms on the first floor.

There was no fitted bath provided.

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

Please state the actions you have taken or are planning to take:
Plans drawn to address the previously identified issues with the care environment had not been actioned as we had initially hoped by July 2015. These plans were not suitable and therefore we needed to re-visit the design of the updates required. We are currently in consultation with Engineers and Architects to meet the requirements with minimal impact on our residents.

All staff have been trained in infection control and regular hand hygiene audits are carried out in the home.
All bedrooms are ensuite and Mystical Rose has had no incidents of infection control outbreaks.
Soiled laundry is processed very effectively within the laundry with no cross contamination occurring to date.
Plans are currently being drawn up to separate the laundry and the sluice area to ensure that any risk of cross infection is further reduced.

All our bedrooms have an en-suite and residents are taken to their own room to avail of toilet facilities.
In addition to the above facilities already in place we endeavour to have addressed the provision of communal toilets on the First floor of the building in a timely manner.

Mystical Rose Nursing Home have a portable bath which can be used in our bedroom's en-suites should any of our residents choose to have a bath in the privacy of their room rather than mobilise to a communal bathroom.
The option of having a bath is already available to all our residents but included in our development plans is the addition of a communal bathroom.

The amendment to the Laundry requires the addition of a new building. Under his advice and taking into account moving of utilities etc. we are looking at a 6 month timescale. Therefore completion of the new Laundry area will be complete by 24th July 2017. This area will also include a separate sluicing area. We have decided on moving the Sluice Machine and Sluice Area from the existing Laundry Area within the next four weeks. This will go into a temporary area until the new structure is complete. The Sluice Area will be separate from 17th February 2017 thus addressing the issue of Cross Contamination.
Proposed Timescale: 24/07/2017