

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	An Teaghlach Uilinn Nursing Home
Centre ID:	OSV-0000309
Centre address:	Kilrainey, Moycullen, Galway.
Telephone number:	091 555 444
Email address:	info@uilinn.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Uilinn Nursing Home Limited
Provider Nominee:	Timothy Bohan
Lead inspector:	PJ Wynne
Support inspector(s):	Gearoid Harrahill
Type of inspection	Announced
Number of residents on the date of inspection:	65
Number of vacancies on the date of inspection:	12

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
14 November 2016 10:00	14 November 2016 20:20
15 November 2016 07:15	15 November 2016 14:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 14: End of Life Care	Substantially Compliant
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 17: Residents' clothing and personal property and possessions	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report set out the findings of an announced registration renewal inspection, which took place following an application to the Health Information and Quality Authority (HIQA), to renew registration of the designated centre.

In applying to renew registration of the centre the provider has applied to

accommodate a maximum of 77 residents who need long-term care, or who have respite, convalescent or palliative care needs. This is the same level of occupancy which the centre is currently registered to accommodate.

The inspectors observed practices, the governance system, clinical and operational procedures and records required by regulation to inform decision making on this registration renewal application inspection. The provider, person in charge and those as participating in management were knowledgeable of the regulatory requirements. They were committed to providing person centered, evidence-based care for the residents.

Questionnaires from residents and relatives were received and the inspector spoke with residents during the inspection. The collective feedback from residents was one of satisfaction with the service and care provided. The actions identified in the report from the last inspection were satisfactorily completed.

The premises, facilities, furnishings and décor were of a high standard. Staff interacted well with residents and in a respectful, responsive and appropriate manner. Staff demonstrated good knowledge of residents' needs, likes, dislikes and preferences. A routine of daily activities was in place and facilitated by activity coordinators.

Safe and appropriate levels of staffing and supervision were in place to maintain residents' safety and meet their care needs. Residents' healthcare needs were met with referrals to medical and allied health professionals.

Seven outcomes were judged as compliant with the regulations and a further eight outcomes as substantially in compliance with the regulations. Three outcomes were moderately non-compliant with the regulations, namely Health and Social Care Needs, Health Safety and Risk Management and the maintenance of records of on-going medical assessment.

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 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

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

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose set out the services and facilities provided in the designated centre and contained all the requirements of schedule 1 of the regulations. The statement of purpose was kept up to date and revised in September 2016.

Judgment:

Compliant

Outcome 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

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

Findings:

The provider has ensured sufficient resources to ensure the delivery of care in accordance with the statement of purpose. There was a defined management structure in place with which staff were familiar. The governance arrangements in place are suitable to ensure the service provided is safe, appropriate and consistent. There was an organisational structure in place to support the person in charge. There is a clinical

nurse manager rostered each day to support nursing staff and report to the person in charge.

There is an operations manager employed who reports to the provider. His role is to oversee the management of the building facilities, maintenance staff, source external contractors and trainers, in addition to supporting in-house training to staff.

There is a reporting system in place to demonstrate and communicate the service is effectively monitored between the person in charge and the service provider. There is a monthly governance meeting planned. This is attended by all the management team.

The areas identified in the last action plan in relation to the audit program were completed. The system to oversee aspects of physical restraint managements (use of bedrails and lap belts) was reviewed. A restraint register was maintained. The audit program requires further expansion to review the use of psychotropic and night sedative medication to ensure enhanced outcomes for residents.

The format to complete a summary report to easily identify trends from data collected requires improvement. In the nutritional audit completed there was no clinical evaluation for some weight loss recorded by some residents. The falls audit did not identify the location of any falls sustained by residents.

An annual report on the quality and safety of care was not complied with copies made available to the residents or their representative for their information as required by the regulations.

Judgment:
Substantially Compliant

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
There was a copy of the residents' guide in each of the resident's bedroom. The residents' guide described the facilities and social activities available and a priced list of additional services available such as physiotherapy or chiropody. The residents' guide explains the type of bedroom accommodation, such as single or twin. Those with or without en-suite bathroom, and the weekly fee that is incurred for each. The residents' guide also contains the complaints procedure.

Inspectors reviewed a selection of contracts agreed between the provider and the residents and their family or representatives. The contracts outlined the accommodation and care services provided. A list of services that are provided in addition to the weekly fee. The contracts were signed by the resident and their representative.

The contracts did not explicitly identify if the room in which the resident was to be accommodated was single occupancy or may be shared with another resident. Some of the bedrooms accommodating one resident were registered as twin rooms. A resident may be unaware that a second person may be accommodated in the bedroom in the future at their time of admission.

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:
The person in charge fulfils the criteria required by the regulations in terms of qualifications and experience.

The person in charge has not changed since the last inspection. She is a registered nurse and holds a full-time post. She had good knowledge of residents' physical and psychosocial care needs. She could describe how staff ensured residents needs were met appropriately.

The person in charge has maintained her professional development and attended mandatory training required by the regulations. There is dedicated time allocated to manage the clinical governance and administration duties required by the post of person in charge.

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):

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

Findings:

Medical records and other records, relating to residents and staff, were maintained in a secure manner. As required by Schedule 3 (4) (e) the records of on-going medical assessment, treatment and care provided by a resident's medical practitioner did not give a clear clinical picture of all medical reviews. Records were not maintained consistently. In some cases there was an electronic record and others on a paper file. In a limited number of cases there were gaps where residents were reviewed and no record of the visit by the prescribing clinician or nursing staff was maintained. Nursing staff recorded visits by allied health professionals or medical practitioners in the daily nursing notes. However, the format did not allow for an accessible and concise review to track the medical history and treatment recommended in each case.

Written operational policies, which were centre-specific, were in place to inform practice and provide guidance to staff.

Appropriate insurance cover was in place with regard to accidents and incidents, outsourced providers and residents' personal property.

The directory of residents contained all the information required by schedule three of the regulations and was maintained up to date.

The complaints procedure was displayed inside main entrance for visitors to view and provide direction to whom they could raise an issue.

A sample of staff files to include the files of the most recently recruited staff were reviewed. The files were examined to assess the documentation available, in respect of persons employed. All the information required by schedule 2 of the regulations was available in the staff files reviewed.

Judgment:

Non Compliant - Moderate

*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:

The provider was aware of the requirement to notify the Chief Inspector of the proposed absence of the person in charge for a continuous period of 28 days.

A key senior manager has been notified to the HIQA to deputise in the absence of the person in charge. This has occurred on one occasion during 2016. The appropriate notifications were submitted within the required timeframes. The person in charge had returned to her post at the time of this inspection.

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):

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

Findings:

There was a policy and procedure on safeguarding vulnerable adults. Staff were trained in the protection of vulnerable adults. Training sessions were scheduled to refresh those for whom the two-year cycle was coming to an end, or new staff who had received basic training on induction. Staff spoken with identified a senior manager as the person to whom they would report a suspected concern.

During conversations with the inspectors residents confirmed that they were well looked after and they felt safe. Questionnaires completed by residents confirmed they were happy. While some expressed a wish to be able to live at home they confirmed they were content with the care provided. Residents spoken with stated "the food is lovely", "something different on the menu each day", "I am well looked after and the staff

always come when I call them". Access to the centre was secured with a coded key pad.

There was one notifiable adult protection incident which is a statutory reporting requirement to HIQA, reported since the last inspection. Timely, thorough and responsive action was undertaken by the person in charge. There was evidence of access to and involvement of social workers to assist residents and explore issues of concerns raised.

A petty cash system was in place to manage small amounts of personal money for residents. Resident's finances were securely maintained in a locked safe. A ledger of lodgement and withdrawals to each resident's account was maintained. These entries were countersigned with copies of receipts. Inspectors reviewed a selection of residents' stored wallets and found the actual balances matched those recorded in the ledger.

There is a policy on the management of responsive behaviour. Staff could describe particular residents' daily routines well to the inspectors. The majority of staff had received training in responsive behaviours. However, a small number of staff were identified as requiring training including new staff who commenced work in the recent past.

There was good access to the psychiatry team. The community mental health nurse visits the centre routinely to review residents and is available to nursing staff via the phone to discuss any concerns. Psychotropic medications were monitored by the prescribing clinician and regularly reviewed to ensure optimum therapeutic values.

There was a policy on restraint management (the use of bedrails and lap belts) in place. On the last inspection the restraint assessments were not reviewed at four monthly intervals. This inspection evidenced risk assessments are now reviewed as part of ongoing assessment. The care plans for residents with bedrails have been reviewed and describe whether the raised bedrail is an enabler or restraint measure. The rationale for the use of bed rails was outlined. The enabling function of bedrails was documented in care plans reviewed. Eighteen residents were provided with a low-low bed and three residents had a crash mat in line with the national policy on promoting a restraint free environment.

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

Findings:

The risk management policy contained the procedures required by the regulation 26 and schedule 5 to guide staff. An up to date health and safety statement and risk register was available.

The fire records confirmed regular testing and servicing of the fire panel, exit routes and doors, emergency lighting and fire fighting equipment by both maintenance staff and external companies.

The centre had conducted two fire drills in 2016 involving 18 staff on a day shift and five staff working at night. The procedures to record fire drills were well documented as required by the action plan of the last inspection.

The reports on the drills noted the time taken to respond to the alarm and the outcome of the fire drill completed and actions for learning for the future. However, there was an inadequate number of fire drills completed to effectively involve all staff. Each staff member did not have the opportunity to participate in an in-house fire drills in addition to annual refresher training.

There was an annual program of refresher training in fire safety in place. At the time of this visit 30 staff were due their refresher training. This was arranged and dates scheduled for the fire safety training to occur planned.

Each resident had a personal emergency egress plan developed. These outlined the method of evacuation and type of equipment required to assist each resident evacuate the building safely. This was an area identified for improvement in the action plan of the previous inspection report.

There was an emergency plan for responding to events such as fire, gas leak or power outage. Arrangements were outlined for transport and accommodation should returning to the centre not be a viable option after an evacuation.

There were procedures in place for the prevention and control of infection. Hand gels were located along the corridor. There were a sufficient number of cleaning staff rostered each day of the week. The inspectors spoke with cleaning staff who explained the cleaning procedures. There was a colour coded cleaning system to minimise the risk of cross contamination. Separate cleaning equipment was available to clean bedrooms in the event of an infection occurring.

Falls and incidents were documented. In the sample of accident report forms reviewed vital signs for residents were checked and recorded. Neurological observations were recorded where a resident sustained an unwitnessed fall or a suspected head injury. While falls sustained by residents were audited periodically, a post incident review was not completed in the immediate aftermath of a fall to identify any contributing factors for example, suspected infection or the impact of changes from medication.

There was sufficient moving and handling equipment available to staff to meet residents' needs. Hoists were available on each floor of the building. Each resident's moving and

handling needs were identified in plans of care and changes communicated to staff at shift handover. The type of hoist and sling size required was specified in risk assessments. This was an area identified requiring improvement from the previous inspection.

The operations manager is a qualified moving and handling instructor. Approximately 15 staff were identified as requiring refresher training in safe moving and handling. This was due to the expiry of their current training in line with the centre's policy. The staff were identified by management and a training date scheduled.

A small proportion of residents smoked frequently on a daily basis. A risk assessment was completed. However, it took cognisance of a limited range of risk factors. A plan of care was not developed following risk assessment. Assessments did not outline if the resident was safe to smoke independently, the level of assistance or supervision required. A smoking area was provided with fire retardant aprons and fire extinguisher. This was monitored by CCTV. As a number of residents chose to keep their own cigarettes and lighters precautions to mitigate any risk were not outlined. The fire policy did not detail the procedures should the clothes of a resident catch fire as required by the regulations.

Judgment:

Non Compliant - Moderate

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:

There was a medication management policy in place which provided guidance to staff to manage aspects of medicines from ordering, prescribing, storing and administration.

There were no residents self medicating at the time of this visit. Medicines were dispensed from blister packs. These were delivered to the centre on a monthly basis by the pharmacist. On arrival, the prescription sheets from the pharmacist were checked against the blister packs to ensure all medicine orders were correct for each resident.

Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medicine and reduce the risk of a medicine error in the sample reviewed. The prescription sheets reviewed were legible. The maximum amount for (prn) medicine (a medicine only taken as the need arises) was indicated on the prescription sheets examined.

The medicine administration sheets viewed were signed by the nurse following administration of medicine to the resident and recorded the name of the medicine and time of administration. The medicines were administered within the prescribed timeframes. There was space to record when a medicine was refused on the administration sheet.

Alternative liquid or soluble forms of the drugs were sought where possible through consultation with the pharmacy. Medicines being crushed were signed by the GP as suitable for crushing.

Medicines were being stored safely and securely in the clinic room which was secured. Medications that required strict control measures were kept in a secure cabinet which was double locked. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift. The inspector checked a selection of the medication balances and found them to be correct.

There was good evidence of pharmacy input to support medication management practices. The pharmacist visited the centre regularly and completed audits of the management of medicines, including reviews of the prescription and administration records, storage and stock management. Advice from pharmacy was available to guide nursing staff on contraindications and other forms of a medicine for those with swallowing difficulty or blood screening for residents on a particular medication over a prolonged timeframe.

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. Quarterly notifications 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):

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

Findings:

There were 65 residents in the centre during the inspection. All residents except two were residing in the centre for continuing care. The remaining two residents were being accommodated for a period of respite care.

The majority of residents were in advanced old age with many complex medical conditions. Seventeen residents were over 90 years of age and 12 over 85 years of age. Twenty three residents had maximum dependency care needs and 15 high level care needs following assessment. Twenty residents had a diagnosis of either dementia, cognitive impairment or Alzheimer's disease as their primary or secondary diagnosis.

There was evidence of regular nursing assessments using validated tools for issues such as falls risk, dependency level, risk of pressure ulcer formation and nutritional deficit. These assessments were generally repeated on a four-monthly basis or sooner if there was a change in a residents condition. Care plans were developed based on the assessments.

Nursing staff demonstrated an in-depth knowledge of the residents and their physical care needs. This was reflected in care plans available for each resident.

Residents admitted for short term care had a discharge care plan completed to guide staff in their rehabilitative goals and ensure a safe discharge. This had been identified as an issue on the previous inspection which is now rectified.

Nursing notes were completed on a twice daily basis and provided a detailed clinical record of each resident's health, condition and treatment given. When an acute health problem was being managed the daily nursing notes described well the interventions, the residents progress and response to treatment.

Care plans for psychological signs and symptoms of dementia (BPSD) and psychosocial care needs require further development. The full extent of some of the issues being managed were not described well for residents with complex mental health problems. Care plans for residents with dementia did not outline information to detail the level of confusion or cognitive impairment, how it impacts on daily life and details such as who

the resident still recognises or what activities could still be undertaken.

Residents had timely access to allied health professionals to include speech and language therapy, dieticians and a physiotherapist. Files evidenced general practitioner (GP) reviews when a resident became unwell at the request of nursing staff.

Reclining chairs were provided for frail residents. However, they were all the same type except for being available in two different sizes. There was no evidence of seating assessments or specialist advice being obtained from an occupational therapist in the recent past. None of the chairs available were fitted with a three point positioning belt. One resident was not facilitated to get up each day as the reclining chair was not suitable to safely meet the resident's needs.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

The designated centre comprised of 35 single and five twin bedrooms on the ground floor. There are 15 single and 8 twin bedrooms on the first floor. There are day sitting rooms on each floor and a dining room located beside the kitchen. There is a lift provided to assist residents move between each floor of the building.

The building was visually clean and well maintained both internally and externally. The corridors were free of equipment. There were no steps or slopes requiring navigation to mobilise throughout the building. Handrails were present along all corridors and stairwells. There was a gap in the handrail on the first floor where floor to ceiling windows were located on either side. The addition of a hand rail to one side requires review to support residents mobilise independently and safely.

There were an adequate number of bathrooms to meet the needs of residents. Any bedrooms that did not have an en-suite were in close proximity to a bathroom along the corridor. En-suite bathrooms were provided with grab rails alongside toilets, wash hand basins and showers. The showers were wet-room in design and easily accessible. All

bathrooms were equipped with call bells.

Bedrooms were spacious and well decorated. There was adequate space for the storage of clothing and personal belongings, including lockable storage for personal items. Privacy curtains were available in bedrooms accommodating two residents.

There were appropriate sluicing facilities available. Access was secured in the interest of safety to residents and visitors. Staff facilities were provided. Separate toilets facilities were provided for care and kitchen staff in the interest of infection control.

There was a sufficient number of hoists, commodes, shower chairs, and other equipment to meet the needs of residents. There was a contract in place to ensure all equipment used by residents was functioning safely.

The building was comfortably warm, ventilated and lit with adequate natural light available to all bedrooms.

There was an enclosed external garden provided with seating available for use by residents.

Judgment:

Substantially Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A complaints policy was available in the main lobby. A copy of the complaints procedure was included in the residents' guide and available in all residents' bedrooms. This identified the procedure which was followed in the event of a verbal or written complaint being made.

An individual was nominated to whom all complaint could be made. The policy included procedures on how to manage written and verbal complaints. A record of all complaints was maintained. No complaints were being investigated at the time of this inspection.

The independent appeals process if the complainant was not satisfied with the outcome of their complaint was not fully meeting the requirements of the regulations. The independent appeals procedures referred complainants to an agency which does not

assist to resolve issues of concern on behalf of residents or an individual not part of the centre's governance structure.

Judgment:

Substantially Compliant

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 inspectors viewed the end of life policy. The policy guided staff in assessing a resident's needs should their health deteriorate rapidly.

There were no residents under the care of the palliative team at the time of this inspection. The nurse management team confirmed community palliative care offers guidance as required in respect of appropriate management of illness. The policy of the centre is all residents are for resuscitation unless documented otherwise. There were 23 residents with a do not attempt resuscitation (DNAR) status in place.

A system of advance care planning was not in place for all residents apart from residents with a (DNAR) documented. There were some residents in advanced old age and at the end stages of their illnesses. Personal or spiritual wishes were not ascertained to ensure social, emotional or psychological needs are met.

Judgment:

Substantially Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

All residents were appropriately assessed for nutritional needs on admission and were subsequently reviewed regularly.

The inspectors observed mealtimes including breakfast, mid-morning refreshments, lunch and teatime. The majority of the residents attended the dining room or day sitting room for their main meals. Residents were offered a varied, nutritious diet. The menu cycle facilitated the preferences of individual residents.

Meals were served in accordance with each resident's dietary requirements including those on modified consistency and special diets. Residents were highly complementary of the food served. There were a sufficient number of staff available to assist those requiring help. Assistance was offered in a discreet and respectful manner to residents. Cold drinks including juices and fresh drinking water were readily available throughout the day. However, it was communicated at handover report access to the kitchen was restricted during the night. A refreshment of choice required by a resident was not available although an alternative was provided.

The special dietary needs of residents were communicated to the catering staff. The inspectors met with the chef. She confirmed that she received an update of the current status of each residents' nutritional requirements and diet consistency. Catering staff had in-depth knowledge of residents' likes and dislikes. The chef stated that if a resident did not like what was on the menu, an alternative was available. The inspector visited the kitchen and noticed that it was well organised and had a supply of fresh and frozen food.

Each resident had a nutritional care plan. All residents were weighed monthly or more frequently if they were identified as being at a higher risk. There was evidence that the recording of a weight loss or gain prompted an intervention if a risk was identified. Access to dietitian and a speech and language therapist was available when required to obtain specialist advice to guide care practice.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

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

Findings:

There was three meetings of the residents' forum were held since January of 2016. Each meeting was well attended with detailed minutes kept. Issues raised at these meetings included suggestions for future events, in-house activities, and trips which the centre could facilitate. The minutes of the meetings included updates detailing the actions and changes which had occurred from the previous meeting.

Questionnaires were circulated to collate residents' views on the facilities, staffing, food and other aspects of living in the centre. There was evidence that feedback from these surveys and meetings, as well as general feedback noted from residents in the day to day running of the centre, were discussed at clinical governance meetings. These are attended by the provider, operations manager, nurse management team, the chef and activities coordinator.

Following from the previous visit, inspectors noted an increase in utilisation of all communal spaces available, as well as furniture placement that allowed residents to interact with visitors and each other more easily and the television was not the sole focal point.

The use of CCTV in all corridors and communal spaces was not accompanied by adequate signage informing residents, families and visitors of its use. Inspectors observed plain signage in corridors and corners of rooms advising of the use of CCTV. The signs did not use colour or imagery to highlight adequately the use of CCTV, nor were they posted in all monitored rooms. Some residents and family members spoken to by inspectors were not sure which areas were monitored. It was not clear which areas residents could receive visitors in private outside of their bedrooms.

On this inspection it was observed there was improved use of the second sitting room. During the morning time a small number of residents on both days of the inspection were engaged in an activity in the sitting room. Continued work is required to maximise the potential of this sitting room to ensure all residents have an alternative choice and minimise over crowding the sitting room on the ground floor beside the dining room.

The centre employed activity coordinators over six days. On two days each week they both facilitated an activity program. They supported residents to engage in daily activities such as bingo, chair exercises, music therapy, arts and crafts, and massage therapy. Residents chose whether or not to participate, and those who did seemed to enjoy the experience and lively interaction was seen to take place. A Sonas program was facilitated in small groups on a weekly basis to provide sensory stimulation for more frail residents.

Judgment:

Substantially Compliant

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a laundry room in which all washing, drying and ironing of residents' clothes was carried out.

On admission, an inventory of the resident's property is recorded. All laundry and ironing is done onsite and there is a full-time laundry staff member present seven days a week. All clothing examined was labelled to identify ownership. There was a system in place to ensure personal laundry was returned to each resident's bedroom.

The laundry room was suitably equipped with industrial sized washers and dryer. There is a separate side room for rinsing of soiled items to minimise the risk of cross infection.

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):

Findings:

All staff files reviewed evidenced staff were Garda vetted. All nurses had records

confirming their active registration with An Bord Altranais agus Cnáimhseachais na hÉireann.

Volunteer files were reviewed. Their roles and responsibilities were set out in writing and Garda vetting was obtained.

The centre maintained rosters for all categories of staff with clear notes as to their actual hours worked due to sick leave, swapped shifts or emergency cover. There was an adequate complement of nursing and care staff on each work shift. The supervision arrangements and skill-mix of staff were suitable to meet the needs of residents taking account of the purpose and size of the designated centre.

There was an induction program for new staff. However, this requires review to ensure all staff are fully competent prior to undertake assigned duties. This is required for new staff rostered for night duty within a short time of completing induction and commencing night duty shifts. Staff during the day were supported with a clinical nurse manger rostered each day of the week.

The inspectors attended a morning and night shift handover report. There was evidence of good communication amongst staff with all staff attending handover report at the change of each work shift.

There was a policy for the recruitment, selection and vetting of staff. Residents spoke positively about staff. Questionnaire submitted to HIQA indicated that staff were caring, responsive to their needs, and treated them with respect and dignity.

Staff were encouraged to maintain their continued professional development. Mandatory training as required by legislation was generally up to date for staff. There was a well developed in house training program and training was facilitated by external trainers.

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:

PJ Wynne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	An Teaghlach Uilinn Nursing Home
Centre ID:	OSV-0000309
Date of inspection:	14/11/2016
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:

The audit program requires further expansion to review additional areas to ensure enhanced outcomes for residents.

The format to complete a summary report to easily identify trends from data collected requires improvement.

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

1. Action Required:

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

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

Monthly audits and quarterly audits are being continued as before. Audit summary report is currently being compiled for audits completed for the month of November 2016.

Completed audit summary report will be reviewed and analysed for further improvements.

Proposed Timescale: 31/01/2017, ongoing

Proposed Timescale: 31/01/2017

Theme:

Governance, Leadership and Management

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

An annual report on the quality and safety of care was not compiled with copies made available to the residents or their representative.

2. Action Required:

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

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

Currently in the process of finalising a template for the annual review.

Annual review of quality and safety of care will be compiled for 2016 and made available to residents within the first quarter of 2017

Proposed Timescale: 30/03/2017

Outcome 03: Information for residents**Theme:**

Governance, Leadership and Management

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

The contracts did not explicitly identify if the room in which the resident was to be

accommodated was single occupancy or may be shared with another resident.

3. Action Required:

Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

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

All current contracts of care updated with the details of occupancy.

All nursing staff are now aware of the requirement to discuss and mention the occupancy on the contract of care for future admissions.

Proposed Timescale: Done, Ongoing

Proposed Timescale: 28/12/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

The records of on-going medical assessment, treatment and care provided by a resident's medical practitioner did not give a clear clinical picture of all medical reviews. Records were not maintained consistently. In a limited number of cases there were gaps where residents were reviewed and no record of the visit by the prescribing clinician or nursing staff was maintained.

4. Action Required:

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

From 01/01/2017, details of all medical reviews will be updated on the documentation software used at the centre. This will assist in providing a comprehensive picture of all the reviews done for each resident.

Proposed Timescale: 01/01/2017,Ongoing

Proposed Timescale: 01/01/2017

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 small number of staff were identified as requiring training in responsive behaviours including new staff who commenced work in the recent past.

5. 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:

Challenging behaviour and safe guarding training is scheduled for 08/02/2017 and three more sessions will be carried during the year.

Policy of managing challenging behaviour is available to all staff .

All new staff members made aware of individual cases of challenging behaviour, their care and management.

Proposed Timescale: 08/02/2017

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:

A post incident review was not completed in the immediate aftermath of a fall to identify any contributing factors for example, suspected infection or the impact of changes from medication.

6. Action Required:

Under Regulation 26(1)(d) you are required to: 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.

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

A post fall assessment is incorporated into the recording system we use at the centre. A meeting with nurses is scheduled for the first week in January to discuss the post fall assessment form.

All slips/trips and falls recorded from 01/01/2017 will have a post fall assessment done to identify the contributing factors.

Proposed Timescale: 15/01/2017

Theme:

Safe care and support

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

Smoking risk assessment took cognisance of a limited range of risk factors. A plan of care was not developed following risk assessment. A number of residents chose to keep their own cigarettes and lighters precautions to mitigate any risk were not outlined. Assessments did not outline if the resident was safe to smoke independently, the level of assistance or supervision required.

7. Action Required:

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

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

Smoking risk assessments are currently being carried out for residents who smoke.

Care plans will be developed based of the assessment findings.

Proposed Timescale: 15/02/2017

Theme:

Safe care and support

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

Approximately 15 staff were identified as requiring refresher training in safe moving and handling. This was due to the expiry of their current training in line with the centre's policy.

8. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

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

Manual handling trainings are scheduled for 11/01/2017, 18/01/2017 and 25/01/2017 to include all staff requiring refresher training.

Approximately six more sessions will be scheduled during the year to include refresher trainings and new staff.

Proposed Timescale: 25/01/2017, ongoing

Proposed Timescale: 25/01/2017

Theme:

Safe care and support

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

The fire policy did not detail the procedures should the clothes of a resident catch fire as required by the regulations.

9. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Fire blankets will be made available to be used in the event of clothes catching fire.

Staff will be made aware of the availability and use of fire blankets.

Proposed Timescale: 15/01/2017

Theme:

Safe care and support

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

There was an inadequate number of fire drills completed to effectively involve all staff.

10. Action Required:

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

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

One fire drill per week scheduled for January and February 2017 to ensure all staff at the centre are involved.

For the remainder of the year, a fire drill will be carried out in every quarter and unannounced drills may be organised as required.

Proposed Timescale: 01/03/2017, ongoing

Proposed Timescale: 01/03/2017

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:

Care plans for psychological signs and symptoms of dementia (BPSD) and psychosocial care needs require further development as they did not contain the full extent of some of the issues being managed were not described well for residents with complex mental health problems.

Care plans for residents with dementia did not outline information to detail the level of confusion or cognitive impairment, how it impacts on daily life and details such as who the resident still recognises or what activities could still be undertaken

11. Action Required:

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

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

Care plans are currently being reviewed. In consultation with the residents/their next of kin and GP details relating to their cognitive impairment and its impact will be detailed in the care plan.

Proposed Timescale: 15/02/2017

Theme:

Effective care and support

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

There was no evidence of seating assessments or specialist advice being obtained from an occupational therapist in the recent past. None of the chairs available were fitted with a three point positioning belt.

12. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

OT assessments were done for residents in June-July 2016 and individuals requiring further OT assessments are referred to OT services by GP.

OT assessment of residents with specialised seating is scheduled for January 2017. Any recommendations for specialist seating will be discussed with the resident and (or) the next of kin.

Proposed Timescale: 25/02/2017

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:

The addition of a hand rail to one side of the corridor on the first floor requires review to support residents mobilise independently and safely.

13. Action Required:

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

We await an instruction from our architects, Associated Design and will install if instructed

Proposed Timescale: 28/02/2017

Outcome 13: Complaints procedures

Theme:

Person-centred care and support

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

The independent appeals procedures referred complainants to an agency which does not assist to resolve issues of concern on behalf of residents or an individual not part of the centre's governance structure.

14. Action Required:

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

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

Complaint procedure of the centre updated with the details of the independent appeals process.

Complaints policy updated with the above mentioned changes and is available to staff

for reference.

Proposed Timescale: Done

Proposed Timescale: 28/12/2016

Outcome 14: End of Life Care

Theme:

Person-centred care and support

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

A system of advance care planning was not in place for all residents apart from residents with a (DNAR) documented.

15. Action Required:

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

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

All staff at the centre have an end of life care assessment completed and will be reviewed again buy 31/12/2016.

Care plans based on the assessment will be done for individual residents.

Proposed Timescale: 31/01/2017

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

Access to the kitchen was restricted during the night. A refreshment of choice required by a resident was not available although an alternative was provided.

16. Action Required:

Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

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

Staff have access to kitchen at all times, food store is kept under lock and key and Nurse on duty has access to the key if required.

Proposed Timescale: Done

Proposed Timescale: 28/12/2016

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

The use of CCTV in all corridors and communal spaces was not accompanied by adequate signage informing residents, families and visitors of its use.

17. Action Required:

Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

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

Six signs regarding CCTV surveillance have been put in place since the inspection. Six more will be erected by 15/01/2017

Proposed Timescale: 15/01/2017