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## Deerpark Nursing Home, OSV-0000222, 2 October 2019

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# Report of an inspection of a Designated Centre for Older People

## Issued by the Chief Inspector

Name of designated centre:	Deerpark Nursing Home
Name of provider:	Deerpark Nursing Home Limited
Address of centre:	Deerpark, Lattin, Tipperary
Type of inspection:	Unannounced
Date of inspection:	02 October 2019
Centre ID:	OSV-0000222
Fieldwork ID:	MON-0027845

## About the designated centre

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

Deerpark Nursing Home was located in a rural area outside the village of Lattin, Co. Tipperary and provided residential services for 33 older people. The centre was purpose built and first opened in 1972. The provider representative informed the inspector that she acquired the center in 1995. The premises had been renovated a number of times over the intervening years and there had been significant improvements and renovation works in the premises in 2016. For example, there had been significant extension completed in 2016 in relation to the reduction in the multi-occupancy bedrooms, extended/renovation of the dining room and provision of new laundry facilities. This had facilitated an increase from 30 registered places to 33 with the addition of seven large single bedrooms, each room has a large en-suite wheelchair accessible shower/toilet facilities. There was suitable outside paths for residents' use and an enclosed courtyard area with planted flower pots and garden seating provided. There was plenty of outside parking provided to the front and side of the premises.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	30
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

### **1. Capacity and capability of the service:**

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

### **2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
02 October 2019	11:15hrs to 19:50hrs	Liz Foley	Lead

## What residents told us and what inspectors observed

Residents told the inspector they were happy living in the centre. Some residents who could not express their own opinions were represented by a family member. Residents felt safe in the centre and were complimentary of staff who they described as kind and helpful. Residents told the inspectors they had choice in their daily lives for example, choice of home cooked meals and some residents had choice over how they spent their day. Some residents told the inspector the routine was different to home where they would have their meals later and go to bed later however they had gotten used to the routine now.

Several residents said they would like more social activities as they felt the day was long and they were often bored. Some residents enjoyed the activities provided and some would like a better choice of activities and would like them more often. The monthly live music was very popular but residents would like it more often. Residents told the inspector that staff were very good but were always busy and they didn't like making too many requests, for example, a late breakfast or to stay up later, as they did not want to put more pressure on the staff.

Residents and families knew how to make a complaint if warranted. Residents and family told inspectors they were welcome in the centre any time.

## Capacity and capability

This was an unannounced risk inspection to monitor compliance with the care and welfare of residents in designated centres for older people, regulations 2013. Unsolicited information had been received prior to the inspection outlining concerns about staffing and infection control. The inspector found non compliance's in both of these areas and more.

Improvements following the last inspection were found in fire safety and doors were no longer wedged open but the provider had installed hold open devices which closed when the alarm sounded. However the condition of fire doors was poor in the centre, two were broken and many doors did not close fully when tested by the inspector. This resulted in increased risk of spread of fire throughout the centre. The provider was aware of these deficits and had not put in place measures to eliminate the risk. An immediate action plan was issued to repair and ensure all doors in the centre closed fully. Maintenance staff were on site before the end of the inspection.

Non-compliances were found in the governance and management of the centre.

This had a significant impact on the quality and safety of the service with further issues found in the centres' infection control procedures, medication management, activity provision, staff supervision, healthcare, care plans and how residents with responsive behaviours and advanced communication needs were being managed.

Quality and safety improvement systems in the centre were ineffective. Obvious risks had not been identified by the service and therefore were not being managed. The accumulated non-compliances found on inspection also indicated that the current quality and safety management systems were ineffective; this resulted in an unsafe environment where vulnerable residents lacked adequate stimulation. Care and welfare issues that had not been identified impacted on the quality of the service provided to some residents particularly those with more advanced communication and behavioural needs.

There were insufficient resources to provide recreational and occupational activities to all residents in accordance with their interests and capacities. Resources were also required to ensure the premises and equipment were in a good state of repair.

### Regulation 15: Staffing

Review of staffing levels was required. Two and a half hours per day was currently allocated to activity provision for 33 residents with varied and specialised needs. Residents with higher dependencies and more advanced needs did not have opportunities to participate in activities in accordance with their interests and capacities. Some residents would like more flexibility in the routine of the centre, for example meal times and bed times which some felt were restrictive.

Shared equipment and cleaning equipment was found to be dirty and areas of the centre had not been deep cleaned. The registered provider told the inspector that deep cleaning had not been done as unexpected leave had not been covered. This required review to ensure that sufficient staffing resources were available to ensure that residents were not at risk of cross infection from unclean equipment. These are further explained under regulations 9 Residents' rights and 27 Infection control.

Three members of staff had recently left the service for various reasons. While all caring and nursing shifts had been covered on the roster, ongoing review was required to ensure that the skill mix and numbers of staff were adequate to meet the assessed needs of all residents.

Judgment: Not compliant

### Regulation 21: Records

Personal identifiable information regarding residents' personal care was displayed on a board in the corridor. This required review to ensure that data was stored in a confidential manner in line with national guidelines.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The systems in place to manage this centre were weak and ineffective impacting on many areas of resident care and resulting in increased risks to the care and welfare of residents and staff in the centre. During the the inspection an immediate action plan in relation to fire safety was issued; this is detailed under regulation 28 Fire precautions.

Ineffective management was evidenced by the high level of regulatory non-compliance found on this inspection including;

1. failure to respond to significant risks to resident and staff safety from broken fire doors and ineffective closure of several fire doors throughout the centre.
2. failure to recognise unsafe medication management practices that not only put residents at risk but also the nurse dispensing the medications.
3. failure to identify risks associated with dirty commodes and the inappropriate storage of clean face cloths in a dirty area. These practices posed a risk of cross infection to residents and were also undignified. There was poor oversight of infection control.
4. poor oversight of maintenance and upkeep of equipment, furniture and premises
5. staff supervision was poor; unsafe practices in medication management and infection control had not been recognised. Insufficient staff resources for activity provision had not been identified.
6. poor records management; personal identifiable information on residents was displayed on a notice board in the corridor.
7. ineffective audit systems.

Risks found on inspection had not been identified by the service and in the case of the fire risk which the provider had identified, no action had been taken to eliminate or mitigate the risk. During the inspection it transpired that the senior management team had different interpretations of how work was organised, which was evidenced in the high level of non-compliance found.

Judgment: Not compliant

## Regulation 34: Complaints procedure

There centre's complaints procedure was displayed in the reception area. There was a nominated person who dealt with complaints and a nominated person to oversee the management of complaints. The centre considered all feedback received both verbal and written and there was evidence of effective management of the complaints viewed. Of the two recorded complaints in 2019 there was good evidence of investigation and learning form the complaint. Residents and family members told the inspector they would know how to make a complaint if warranted.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff supervision was poor and required review. This was reflected in several regulations, for example, regulations' 27 infection control, 9 Residents' rights, 29 Medicines and pharmaceutical service, 6 Healthcare and 7 Behaviour that challenges.

Additional staffing and training resources were required to ensure all residents occupational and recreational needs were being met in accordance with their interests and capacities.

Judgment: Not compliant

## Quality and safety

Accumulated risks in the centre impacted on the quality of life of residents living there. Equipment, furniture and some areas of the centre required repair and replacement. Poor infection control practices increased the risks of resident's acquiring healthcare associated infections and impacted on their dignity. Risk management was poor with current systems failing to identify risks, therefore active risks were not being managed.

Healthcare provided to residents was not always evidence-based. Observations made by the inspector of care provided were concerning. These issues were discussed with the management team on inspection who took some steps to improve the situation. A full review of care practices was required to ensure that care provided was appropriate to each resident's needs, was safe and based on best practice.

Referrals to specialist allied health professionals were not always made in a timely manner. One resident with obvious specialist seating needs had not been referred to an occupational therapist and as a result did not have appropriate seating. This restricted the length of time this resident could get out of bed for and further impacted on their social wellbeing. Nursing assessments and interventions had failed to meet the needs of residents with advanced communication needs, these residents were not referred to speech and language services for assessment and were not afforded opportunities to find solutions to their communication difficulties.

Care plans were not guiding staff on basic care needs of residents. Daily hygiene requirements were not adequately addressed in care plans however staff were familiar with individuals' needs and described person-centred interventions. Ongoing non-compliance was found in the assessment and identification of responsive behaviours; the service continued to fail to identify triggers to episodes of responsive behaviours. This impacted on residents in many ways, for example, inappropriate use of sedating medication, increased episodes of responsive behaviours and lost opportunities to distract residents with the provision of appropriate recreational activities.

Medication practices were putting residents at risk of medication error and were not in line with the Nursing and Midwifery Board of Ireland's *Guidance to Nurses and Midwives on Medication Management*.

Residents were not always provided with opportunities to participate in activities in accordance with their interests and capacities. Residents who could participate in group activities had limited opportunity to do so. The activities offered were enjoyed by some residents however more variety was required and more opportunities to enjoy social activities. Residents with advanced needs were often not provided with opportunities to participate in activities as the centre did not have the expertise or staff resources to do so.

Routines in centre required review to ensure they were not restricting residents choice for example bedtimes, meal times and activities.

## Regulation 10: Communication difficulties

Residents with communication difficulties were not always supported to communicate freely. Care plans for these residents did not guide staff on specialised communication strategies required to communicate with these residents. Residents had not been referred to specialised services, for example, speech and language therapy to assess their communication needs.

Judgment: Not compliant

## Regulation 17: Premises

Some improvements were found following the previous inspection including a new floor in a shared bathroom. Further improvements were required to ensure the environment was in compliance with the matters set out in schedule 6 of the regulations, for example, areas of the centre required painting, equipment and furniture required repair or replacing.

Judgment: Substantially compliant

## Regulation 27: Infection control

Procedures for the prevention and control of healthcare associated infections in the centre required review. The following issues were found which impacted on the safety and welfare of residents and were not in line with best practice or national standards;

- There was no personal protective equipment in the sluice room for staff to use when decontaminating dirty equipment.
- Commodes stored in a communal bathroom were visibly dirty and one was worn therefore difficult to clean.
- There was no record of deep cleaning of commodes; these are high risk as they are shared equipment.
- A resident's chair was also stored in a communal bathroom; this was also worn and therefore difficult to clean.
- Furniture and equipment throughout the centre required repair or replacement, for example, a sofa and reclining chair in a lobby area were torn, damaged bedside locker and storage of supplies in a bath in the main bathroom. These issues were not identified or reported to maintenance.
- Urinals and commode pots were incorrectly stored in the sluice room and urinals were seen in shared bathrooms.
- Clean face cloths used for residents' personal hygiene were stored on a shelf in the dirty sluice room. While this was posing a risk to residents' safety it was also undignified.
- Disposable wipes were not available for staff to use when assisting residents with aspects of personal hygiene. Face cloths were also used for intimate care and while these were colour coded they were re used, this was not in line with best practice.  
The housekeeping trolley was visibly dirty inside and outside.
- Chemicals were stored unsecured in the sluice room. Toiletries were stored in the bath and in an open cupboard in a communal bathroom.

Oversight of infection prevention and control was poor. Above risks were not

identified by the service and therefore residents and staff were at increased risk of transmission based infections. There was no quality and safety improvement plan to address the failings.

There was a deep cleaning schedule and in September several areas of the centre were not deep cleaned due to staff shortages. The provider was undertaking to review this.

Residents personal laundry was washed in the centre and there were adequate systems in place to safely manage this.

Judgment: Not compliant

### Regulation 28: Fire precautions

The registered provider did not have adequate arrangements in place to contain the spread of fire. Doors throughout the centre were not closing fully and two doors were found to be in a state of disrepair and unable to close fully. The door closing device on one door was broken. While improvements were found in the addition of hold open devices on bedroom doors, the doors were not checked on a regular basis to ensure they were complaint and would function properly in the event of a fire. This was discussed with the registered provider during the inspection and an immediate action plan was issued.

Maintenance staff attended the centre during the inspection to adjust the doors.

Judgment: Not compliant

### Regulation 29: Medicines and pharmaceutical services

The centre had a medication management policy to guide nurses in the safe administration of medications. This policy required review to ensure that nurses were adequately guided when transcribing medication kardex's in line with guidance set out by the nursing and midwifery board of Ireland and HIQA. Transcribing medications is a high risk activity that requires an advanced level of competency which should inform the nurses' decision to transcribe. These were not covered in the policy nor were other risks associated with transcribing identified. Transcribing was not subject to audit and therefore this high risk activity was not effectively monitored to ensure safety and quality improvement. The risk of medication errors was therefore increased and likely to go unnoticed.

Health care assistants were routinely administering medications to residents unsupervised. This was a custom that was not supported by a policy and staff were not trained to do so. Nursing staff were handing medications to care staff and

signing for their administration. This was not in line with the guidelines set down by the nursing and midwifery board of Ireland and required immediate review as it put residents at risk.

Medication kardex's required review to ensure that medications occasionally required by residents had an indication for use and a maximum daily dose for use. Psychotropic medication which has a sedating effect was used as required for the management of responsive behaviours. These medications were routinely administered without an adequate assessment of the residents' needs. Therefore physical causes of responsive behaviours were not considered or identified nor were environmental triggers identified. This practice was not evidence-based and may impact on residents' wellbeing and quality of life.

Three monthly reviews of residents' medications were not routinely completed. Medication orders were routinely taken over the telephone from the GP and transcribed onto the medication kardex by one nurse. This practice required review to ensure it was in line with best practice and the centre's policy which states that two nurses must listen to and independently confirm the order before recording it on a dedicated form.

Judgment: Not compliant

### Regulation 5: Individual assessment and care plan

Some improvements in the assessment of residents' social needs were found however these assessments did not consistently inform the residents care plans. Ongoing non-compliance was found in the identification of behavioural triggers and therefore care plans did not guide staff in person-centred techniques to de-escalate responsive behaviours. Opportunities were lost to identify behavioural triggers and provide a comprehensive person centred schedule of activities based on need.

Care plans for residents' personal hygiene failed to identify individuals' needs however staff were familiar with residents' daily needs. Some residents did not have an end of life care plan. End of life care plans viewed did not address fundamental issues like resuscitation preferences and therefore staff were ill equipped to provide care at a resident's end of life, particularly if there was a sudden deterioration in a residents condition.

Judgment: Not compliant

### Regulation 6: Health care

Some residents with specialised needs did not have appropriate or up to date

assessment by allied health professionals'. One resident was observed in an old worn reclining chair which belonged to the centre. This resident who had mobility and balance needs and who was also at risk of developing a pressure ulcer had not been assessed by an occupational therapist. While the resident did not develop a pressure ulcer the major impact was on the long periods of time spent in bed for the residents comfort. This required review. Another resident who had an OT assessed chair required review to replace a worn part on the chair.

One resident with swallowing difficulties and who was on a modified diet had not been reviewed by the speech and language therapist since May 2017. This required review to ensure that care provided was based on the resident's current needs.

Care provided was not always evidence-based. The inspector observed care provided to a resident on the afternoon of the inspection that failed to meet their need. The outcome for the resident was the receipt of a sedating medication in the absence of a basic pain or behavioural assessment. This was discussed with the person in charge during the inspection who ensured the resident received pain relieving medication. The resident had multiple co-morbidities and on review of the care plan also required a referral to palliative care services to manage their symptoms.

Poor medication practices also put residents at risk of medication errors and nursing staff were working outside of the nursing boards' guidelines. This is discussed further under regulation 29 Medicines and pharmaceutical services.

Judgment: Not compliant

## Regulation 7: Managing behaviour that is challenging

Restrictive practices in use in the centre included bed rails, restricted chair and key-coded doors. The person in charge assured the inspector that safety checks on restrictive practices such as bed rails were carried out two hourly in line with the national guidelines. There was open access to the centre's internal courtyard and residents enjoyed accessing this space when weather allowed. A review of bed rails was required to ensure that residents who requested bed rails for comfort had half bed rails available to them as a less restrictive option. Review of the restricted front door was required to ensure that all residents that did not require restrictive practices were not negatively impacted on.

Ongoing non-compliance was found in the management of residents who had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). There was no evidence that episodes of responsive behaviours were assessed in order to identify triggers and develop strategies to deescalate and prevent further recurrences. Physical and environmental causes of responsive behaviours were not assessed and therefore residents were not receiving

care in accordance with their assessed needs or in line with best practice.

Judgment: Not compliant

### Regulation 9: Residents' rights

There were limited facilities and opportunities for residents to participate in activities. The inspector was told that activities were provided from 1pm to 6pm daily however it was found that activity provision only occurred from 1pm to 3.30pm. Social needs were assessed however these did not always inform the residents care plans. This was particularly important for residents with dementia who could not tell staff what activities they enjoyed or were interested in. Participation in activities was recorded however the level of engagement was not therefore it was not evident that those activities provided were in accordance with residents' interests and capacities. Long periods of inactivity were observed in the day room on the day of inspection. Residents with communication difficulties who could not express their needs or participate in groups were not receiving sufficient individual stimulation. These residents did not have individual sensory items and did not receive daily one-to-one recreational activities. Staff who were responsible for activity provision had not received any training in the provision of sensory activities for residents with dementia.

Residents who could participate in group activities told the inspector they enjoyed some of the group activities, particularly the exercises provided by an external physiotherapist. Residents told the inspector they would like more activities and would like more variety. Live music was provided monthly and residents who enjoyed this would like it more often.

There was a choice of meals and residents complimented the food quality and quantity. The centre's routines may be impacting on residents' choice, for example, two residents told the inspector they normally had their breakfast after 9.30am however they received breakfast before 8.30am and said the reason they did not complain was that staff were too busy in the morning and they did not want to cause a fuss. This was discussed with the management team who told the inspector that residents could have meals late if they asked but that none had and that breakfast was finished at 8.45am most days. Meal times were approximately 8am, 12pm, 4pm for main meals and snacks were provided between 6-8pm. Residents that could request snacks later were facilitated by the night staff. Residents that required assistance with meals generally received meals 15 minutes before others. This was repeated for the evening snack with assisted snacks provided first leaving a potential fast of 14 hours for resident's who required assistance. It is notable that these residents are often unable to communicate their needs. This required review to ensure routines were not overly impacting on quality of life and choice.

Privacy was respected and there was access to TV, radio and papers daily.

Independent advocacy services were advertised in the centre.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 16: Training and staff development	Not compliant
<b>Quality and safety</b>	
Regulation 10: Communication difficulties	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

# Compliance Plan for Deerpark Nursing Home OSV-0000222

Inspection ID: MON-0027845

Date of inspection: 02/10/2019

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

**Section 1**

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

**Compliance plan provider’s response:**

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:            Activity hours are now 12pm – 4pm daily seven days a week. A Key to me assessment shall be carried out on admission to develop an understanding of each resident and an activities care plan shall be developed to try and ensure that each resident has a fulfilled day in line with their wishes , with the input of the residents gathered from discussions and resident meetings. In addition to this we have Fit for life twice weekly 1.30pm – 4.30pm. mass weekly, also on TV and radio for residents. Our musicians are now increased to twice monthly            All our residents have been surveyed as regards mealtimes and we are quite willing to fit in with their wishes, however they are all in agreement that they like the mealtimes and do not want them to change            2 full time cleaners recruited. New cleaning rosters now in progress to ensure all areas and equipment are cleaned to high standards. Environmental Cleanliness Audit tool to be implemented to ensure quality of service. Spot checks and routine checks to be done. Staffing rosters are now geared to ensure skill mix between senior and junior staff where possible to ensure needs of residents are met.</p>	
Regulation 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:            Personal identification regarding resident’s personal care has now been removed from display boards in NH. We continue to strive to adhere to regulations and preserve the privacy and dignity of our residents</p>	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- All fire doors full closures adjusted and completed on day of inspection by maintenance. Now fully compliant, new rosters and check list set up for regular checking and reporting of any defects. Audits continue to be completed on a monthly basis and weekly checks for all doors in progress.
- Poor medication administration practices has been addressed, all SN are in the process and updating on line medication management ( HSEland) and will be completed by 29th February 2020. Supervision to maintain standards will continue after training is completed and subsequent spot checks will be recorded, and action taken if needed. Our pharmacy will assist us in our audit process from Jan 2020.
- "dirty equipment" which inspector referred to on day of inspection was face cloths, were actually clean face cloths that were stored in the Sluice room, We agree that this practice was unacceptable however, it was an oversight, and all staff have been advised of the inappropriateness of same. We had a policy of using both light and dark coloured for different body areas, these were washed daily at 90 degrees, since inspection we no longer use these and have disposable cloths for personal hygiene needs.
- We shall review our maintenance records and develop a system of checks that should ensure that equipment, furniture and premises are maintained in a timely manner Audit systems will be amended and improved by end of Feb 2020 to ensure to capture areas that have been identified that need to be improved,

Regulation 16: Training and staff development	Not Compliant
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Both activity co ordinators have recently been on a two-day course to assist them in their job.

Two yearly mandatory trainings have been completed by PIC this year for all staff. Staff nurses have access to HSEland to allow them to complete online trainings, also they are encouraged to source courses to assist them in their roles. We shall continue to monitor staff during working hours to observe if their working practices are in line with recommendations and are always available to discuss with staff any difficulties they may have and provide support where needed.

PIC to undertake a course to update her knowledge in areas that need improvement, esp behaviors that challenge, this then will be circulated to staff to enable then to ensure all residents needs will be met.

Regulation 10: Communication difficulties	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 10: Communication difficulties:</p> <p>Residents with communication difficulties following assessment will be referred to appropriate services.</p> <p>Care plans will be developed with residents and NOK to guide staff on specialized communication strategies required to communicate with these residents.</p> <p>We are now providing pictorial guidance for meal choice to assist resident choice.</p> <p>Staff made aware of any resident with communication difficulties at hand over, training to be developed in this area.</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>Since inspections room 1 is in the process of being fully upgraded at present.</p> <p>Room 7 and 12 are in the pipeline to be upgraded early 2020.</p> <p>Maintenance book is available for all staff , especially staff who clean specific items of furniture, to document faulty equipment and any furniture requiring repair or replacement.</p> <p>As previously stated, we will develop auditing methods to oversee our maintenance schedule</p>	
Regulation 27: Infection control	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 27: Infection control:</p> <p>Staff now have daily allocated tasks to ensure PPE remain stocked up and ordered / no items in main bath.</p> <p>Cleaners now have new rosters which are up and running to ensure better standards, also included in audits. Staff are aware of the importance of being vigilant and if defects are observed to ensure they are recorded so they can be maintained as quickly as</p>	

possible.

We now have since inspection a new storage rack for urinals, no urinals are stored in shared bathrooms anymore. Deep cleaning roster for commodes is now activated and records maintained.

We do not use face cloths any more since inspection for personal hygiene needs we use disposable cloths.

The housekeeping trolley after day of inspection was thoroughly cleaned by cleaners, they now have a cleaning roster for regular cleaning / checking of trolley.

Chemicals are now stored in a locked cupboard in sluice room.

Staff are appointed daily to ensure no inappropriate equipment is stored in the bathroom.

We are in the process of researching, with the aid of the HSE guidelines in Infection Control, improved systems to ensure the safety of our residents and to improve our Infection Control management

Regulation 28: Fire precautions

Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

All doors now close fully.

Doors broken, were fixed on day of inspection, and compliant with regulation. New doors are now in place.

Door closing device was fixed on day of inspection by maintenance.

We now have recorded weekly checks in place to ensure all doors close correctly to ensure compliance, if any issues to be documented in maintenance book.

Regulation 29: Medicines and pharmaceutical services

Not Compliant

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

New medication transcribing policy in place, in line with NMBI and HIQA.

The practice of SN giving medication to HCA has now ceased, as previously mentioned all SN are in the process of completing medication management on line (HSEland).

We have now since had 2 meetings with pharmacist who has agreed to commence generating our drug kardex, to include PRN medication and max dose in 24hours.

It has been identified that the area of responsive behaviours needs to be improved, PIC has sourced an appropriate course and will ensure all staff are updated with current knowledge.

We will also be using the ABC assessment to guide our practice in dealing with responsive behaviours. Each resident who presents with responsive behaviours will have a care plan developed to identify triggers and suggest distraction methods to alleviate anxiety etc.

All residents are up to date with 3 monthly medication reviews from their GPs.

We now have a process in place which is also documented that if we do need to receive a telephone order from GP that this is heard by 2 staff independently to confirm the order, before recording it on a dedicated form.

We shall continue to monitor Medication practices to ensure they are in line with policy

Regulation 5: Individual assessment and care plan

Not Compliant

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

We shall be using the Key to Me assessment to assist us in establishing our residents social needs and each resident shall have a dedicated Meaningful activities care plan to ensure fulfillment of each residents personal wishes

Care plans regarding personal hygiene have been developed to guide care.

It has been identified that staff require extra guidance regarding the identification of Behavioral triggers in order that we can be guided in person centered techniques to de-escalate responsive triggers. The PIC has sourced a course to improve her knowledge and also to circulate this information to staff to be able to provide a person-centered assessment and care plan.

We will also be using the ABC assessment to guide our practice in dealing with responsive behaviours. Each resident who presents with responsive behaviours will have a care plan developed to identify triggers and suggest distraction methods to alleviate anxiety etc.

We have tried to establish, with each resident, clear end-of-life wishes and where possible, they are specified in regards to resuscitation, hospital admission etc.

Regulation 6: Health care

Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

The defective chair has now been fully recovered. OT in Clonmel had been contacted by both phone and letter. They replied back that they are not able to do seating assessment

at this time in the community. We will still continue to send them any requests for OT assessments.

A visiting OT kindly assessed resident for us and she has advised that this chair is most suitable for this man as this chair which is "tilting is suitable for him".

The man needing a new part for his chair has been issued with a new chair.

I have been contacted by SALT as there is new guidelines regarding thickened fluids and modified diets all residents will be reviewed. All have been reviewed except one lady who has an appointment in the coming weeks.

Regulation 7: Managing behaviour that is challenging	Not Compliant
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

All able residents have the code for the front door to NH. All relatives and NOK also have access to the number. There are no lap belts in use in NH. We will risk assess each resident in regard to using outside areas safely

We will continue to strive for restraint reduction and will review frequently the use of bed- rails to try and reduce where possible, while taking resident wishes into account

We shall commence using the ABC assessment following an incident of challenging behavior to identify triggers and improve practice.

Improvement will commence in the identification of triggers of responsive behavior, by sourcing an appropriate course as already documented.

Care plans to be developed for residents who display challenging behaviours following assessment.

Regulation 9: Residents' rights	Not Compliant
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Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Activities have now been changed and times are now 12 pm – 4pm daily. Both activity Co Ordinator's have recently been on a 2-day course to assist them in their job. We have purchased a lot of activity material and games to encourage more diverse and stimulating activities.

A key to me is completed as soon as able on admission to guide staff towards successful activities with dementia residents' families are involved to allow staff to direct appropriate activities to these residents.

Rummage boxes now available and are very successful with one resident.

We now have new activity planners which are on display for all staff and residents to see what is going on.

All residents enjoy the music sessions which we now have twice a month.

The inspector on the day of inspection felt that residents did not have enough choice over mealtimes.

Following inspection I with the kitchen staff went to individual residents and spoke to them about this, 2 ladies did request their lunch later which was agreed by kitchen staff however during the discussion when they discovered that all their friends who they have lunch with was still having lunch at 12.30pm they decided that they would like to stay at original time as they enjoyed having lunch with them. One man often only has a sandwich at lunch time and his meal in the evening, then reverts back again whichever he chooses.

We continue to provide our residents with choice regarding all daily routines. We discuss their choices on admission and during residents meetings

All our residents are always afforded a choice regarding their daily lives, including mealtimes and we have no difficulties in providing meals outside of structured times Snacks, food and drink are all available to all residents 24/7. Staff have been instructed to encourage all residents to ask for food whenever they would like it. All residents are long term and are well known to all staff, all likes and dislikes food record are completed with kitchen staff, NOK and residents on admission.

All relatives when visiting are offered tea, coffee and snacks by staff.

## Section 2:

### Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 10(1)	The registered provider shall ensure that a resident, who has communication difficulties may, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre concerned, communicate freely.	Not Compliant	Orange	30/11/2019
Regulation 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Not Compliant	Orange	30/11/2019
Regulation 15(1)	The registered provider shall ensure that the	Not Compliant	Orange	12/12/2019

	number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/01/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/12/2019
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2020
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	08/11/2019
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Substantially Compliant	Yellow	31/03/2020

	the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/03/2020
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/01/2020
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/11/2019
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape,	Not Compliant	Orange	08/11/2019

	building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	08/11/2019
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	08/11/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	08/11/2019
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	08/11/2019
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with	Not Compliant	Orange	30/01/2020

	paragraph (2).			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	31/12/2019
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/11/2019
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/11/2019

Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	31/12/2019
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant		31/12/2019
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	30/01/2020
Regulation 7(2)	Where a resident behaves in a manner that is challenging or	Not Compliant	Orange	30/01/2020

	poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	31/12/2019
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/12/2019
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/12/2019
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does	Not Compliant	Orange	31/12/2019

	not interfere with the rights of other residents.			
Regulation 9(3)(c)(i)	A registered provider shall, in so far as is reasonably practical, ensure that a resident information about current affairs and local matters.	Substantially Compliant	Yellow	31/12/2019