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An Teaghlach Uilinn, Kilrainey, Moycullen, Galway

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Health Information and Quality Authority
Regulation Directorate

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

Centre name:	An Teaghlach Uilinn
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):	None
Type of inspection	Announced
Number of residents on the date of inspection:	65
Number of vacancies on the date of inspection:	5

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

The inspection took place over the following dates and times

From:	To:
02 March 2016 10:15	02 March 2016 19:00
03 March 2016 08:20	03 March 2016 01:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially 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 11: Health and Social Care Needs	Substantially Compliant
Outcome 14: End of Life Care	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report set out the findings of an unannounced monitoring inspection. This inspection took place over two days. The inspector reviewed progress on the action plan from the previous inspection. Notifications of incidents received since the last inspection was also considered and reviewed on this visit.

The centre was clean, warm and well decorated with a calm atmosphere. Residents were complimentary of staff and satisfied with care services provided. Residents had good access to nursing, medical and allied health care.

The management structure was appropriate to the size, purpose and function of the centre. The inspector observed that residents were treated well, with safety at the forefront of care.

There was an adequate complement of staff with the proper skills on each work shift. However, the deployment of care staff and assignment of work practices requires review.

A total of 11 Outcomes were inspected. Two outcomes were judged as compliant with the regulations and a further six as substantially in compliance with the Regulations. The inspector judged three Outcomes as moderately non-compliant. These included Health, Safety and Risk Management, End of Life Care and Residents' Rights, Dignity and Consultation.

The areas of moderate non-compliance primarily related to;

Fire drill practices require review to ensure simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced. Personal emergency evacuation plans were not developed for each resident.

Resident's preferences with regard to transfer to hospital if of a therapeutic benefit, personal or spiritual wishes for end of life care were not documented for all residents.

The use of communal areas requires review to ensure sufficient space for residents to meet their personal, social and recreational.

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

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

Findings:
The Statement of Purpose was last updated in May 2014. 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.

However, the Statement of Purpose required review to outline the arrangements of the centre when the person in charge is absent. The details of the deputy to the person in charge were not detailed.

Judgment:
Substantially 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

Findings:
There was a defined management structure in place to ensure the effective governance of the service. The inspector found that the management structure was appropriate to the size, ethos, purpose and function of the centre. There was an organisational structure in place to support the person in charge.

There was evidence of quality improvement strategies and monitoring of the services. The inspector reviewed audits completed by the person in charge. The medication management audit was completed by an external pharmacist and outlined action plans for improvement.

However, the audit program requires review to ensure a defined set of criteria are reviewed regularly and systemically. The nutritional audit was completed monthly till June 2015 and every three months for the remainder of the year. There was evidence of referrals to a speech and language therapist and dietician arising from the audit review. The falls audit requires review to identify trends within the data collected and reviewed. The review did not assist to identify repeat falls by individual residents and there was no correlation between the times falls occurred and staff levels. The audit was not completed at regular intervals during the year to identify any corrective action at the earliest stage possible. Similarly the system to oversee aspects of physical restraint managements (use of bedrails and lap belts) requires review. A restraint register was not maintained.

An annual report on the quality and safety of care was not compiled for 2015 with copies made available to the residents or their representative for their information as required by the regulations.

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

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

The person in charge is a registered nurse and is noted on the roster as working in the post full-time. The post of person in charge is supported by a clinical nurse manager five days per week.

The management team had good knowledge of residents care needs. The person in charge could describe in an informed way where residents had specific needs and how staff ensured that their care needs were met appropriately.

The person in charge has maintained her professional development and attended mandatory training required by the regulations. Since the last inspection the person in charge has completed a Further Education and Training Awards Council (FETAC) Level 6 course in Leadership and Management in Nursing Homes.

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

Findings:
The inspector found that there were systems in place to maintain complete and accurate records. Records were stored securely and easily retrievable.

Written operational policies, which were centre specific, were in place to inform practice and provide guidance to staff. The centre's polices were only available in an electronic format. While the polices were being introduced in this way to staff, only ten of the Schedule 5 polices were accessible to staff on the electronic system. There was no paper copy for staff to reference until all polices are accessible on the electronic system.

A sample of five staff 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.

A directory of residents was maintained up to date. The inspector noted the details of the most recent admission and most recent death were recorded in the directory.

Records were stored securely and easily retrievable.

Judgment:
Substantially 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

Findings:
There were effective and up to date safeguarding policies and procedures in place. Risks to individuals were managed to ensure that people had their freedom supported and respected. There were sufficient numbers of suitably qualified staff on each work shift to promote residents independence.

Residents spoken with stated that they felt safe in the centre. The front entrance door was secured. There was a visitors log in place.

Staff training, supervisions and appraisals were completed. The person in charge has qualified as a trainer in adult protection since the last inspection. Staff had the knowledge, skills and experience they needed to carry out their roles effectively. The inspector observed and saw that residents were treated well, with safety at the forefront of care and support provided appropriately.

Staff spoken with were able to inform the inspector of what constituted abuse and of their duty to report any suspected or alleged instances of abuse. Staff identified a senior manager as the person to whom they would report a suspected concern. The inspector

viewed records confirming there was an ongoing program of refresher training in protection of vulnerable adults in place.

There is a policy on the management of behaviour that is challenging. Staff spoken with were very familiar with resident's behaviours and could describe particular residents' daily routines very well to the inspector. Staff had completed training in behaviours that challenge. Further training was planned for April 2016 for the additional staff. The inspector reviewed the file of an involuntary admission to a secure unit from the centre. The processes to ensure the well being of the resident were supported by external health professionals.

Where residents had specialist care needs such as mental health problems there was evidence in care plans of links with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication to ensure optimum health. It was evidenced in medical files the community mental health nurse visited the centre routinely.

There was a policy on restraint management (the use of bedrails and lap belts) in place. A restraint free environment was bring promoted. At the time of this inspection there were 13 crash mats in use. Beds were placed to the lowest level and sensor mats were available for use. Bumpers were placed over bedrails to minimise risk of injury for residents with poor skin integrity or those with involuntary movement.

A risk assessment was completed prior to using bedrails. Signed consent was obtained. There was evidence of multi disciplinary involvement in the decision making process. However, the restraint assessments were not reviewed at four monthly intervals. The documentation did not outline or describe well how the raised bedrail supported the resident and ensured an enabling function in each of the assessments reviewed.

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

Findings:
The risk management policy contained the procedures required by the regulation 26 and Schedule 5, to guide staff. Responsibility for health and safety procedures and an organisational safety structure was included in the risk management policy and health and safety statement.

There were arrangements in place for appropriate maintenance of fire safety systems such as the fire detection and alarm system. Illuminated fire exit signage was in place.

Action notices detailing the procedures to take in the event of discovering a fire or on hearing the alarm were displayed around the building.

Staff had completed training in fire safety evacuation procedures. Newly recruited staff were familiarised with the fire precautions on induction and prioritised for training by a competent external trainer who visited the centre twice during the year.

Records indicated fire drill practices were completed. However, the number completed require review to ensure all staff have the opportunity to participate to include staff only rostered for night duty. The drills did not record the scenario or type of simulated practice. Records did not evidence simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced. The fire drill records did not detail the time taken for staff to respond to the alarm or evacuate a zoned compartment. There was no evaluation of learning from fire drills completed to help staff understand what worked well, identify any improvements required and share learning.

The evacuation procedure in the event of a fire was one of phased, progressive horizontal evacuation of the building. The needs of the residents had not been assessed in the event of an evacuation of the centre. Personal emergency evacuation plans were not developed for each resident. A risk assessment to identify the most appropriate aids suitable to residents capability to assist them safely evacuate in a timely manner both during the day and at night while resting in bed were not developed.

There were was a number resident who smoked at the time of this inspection. A smoking room was provided. Risk assessments were completed. Two residents smoked in their bedroom. A plan of care was in place detailing the level of assistance and supervision required. Protective equipment was provided to include a smoking apron.

The building, bedrooms and bathrooms were visually clean. There was a colour coded cleaning system to minimise the risk of cross contamination. A sufficient number of cleaning staff were rostered each day of the week.

There were arrangements in place for recording and investigating untoward incidents and accidents. The inspector noted that falls and near misses were well described. 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. However, a post incident review was not completed to identify any contributing factors for example, changes to medication or onset of an infection or a pattern in risk leading to a fall by a resident.

The training records showed that staff had upto date refresher training in moving and handling. Further training was planned for staff for April. Six staff required refresher training. There was sufficient moving and handling equipment available to staff to meet residents needs. There was a contract in place to service all equipment use by residents to ensure it was functioning safely.

Each resident's moving and handling needs were identified and available to staff at the point of care delivery. While the type of hoist to be used was identified the sling size was not detailed.

Hand testing indicated the temperatures of radiators or dispensing hot water did not pose a risk of burns or scalds. Restrictors were fitted to upstairs windows. Access to work service areas to include the kitchen and sluice rooms and stair wells was secured in the interest of safety to residents and visitors.

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

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

Residents were facilitated with a choice of pharmacist. At the time of this inspection two residents received their medication from the pharmacist they used prior to moving to the centre.

Each resident's medication was dispensed from blister packs. The blister packs on arrival were checked against the prescription sheets in the signed kardex to ensure all medication orders received were correct for each resident. Drugs which were crushed prior to administration were prescribed and signed by the GP.

The inspector reviewed a sample of drugs charts. Photographic identification was available on the drugs chart for each resident to ensure the correct identity of the resident receiving the medication and reduce the risk of medication error. The prescription sheets reviewed were legible and easy distinguish between PRN (as needed), regular and short term medication.

There were three medication trolleys to facilitate the administration of medication. The medication administration sheets viewed were signed by the nurse following administration of medication to the resident. These recorded the name of the drug and times of administration. The drugs were administered within the prescribed timeframes. There was space to record when a medication was refused on the administration sheet.

Medications that required strict control measures were kept in a secure cabinet which was double locked in keeping with the Misuse of Drugs (Safe Custody) regulations. 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 balances and found them to be correct.

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

Findings:
There were 65 residents in the centre during the inspection and one resident in hospital. There were 27 residents with maximum dependency care needs. Ten residents were assessed as highly dependent and 27 had medium dependency care needs. Five residents were assessed as low dependency.

The majority of residents were in advanced old age. Sixteen residents were over 90 years of age and 21 over 80 years of age. Eighteen residents were over 70 years of age. There were four residents between 50 and 60 years old. All residents were noted to have a range of healthcare issues and the majority had more than one medical condition. Thirty eight residents had a diagnosis of either dementia, cognitive impairment or Alzheimers.

The inspector reviewed four resident's care plans in detail and certain aspects within other plans of care. This included the files of residents with nutritional issues, protective dressings, potential behaviour that challenges, high risk of falls, a recently admitted resident for short term care and a resident who had a hospital admission.

On admission a comprehensive assessment of needs was completed. Recognised assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration, for example vulnerability to falls, dependency levels, nutritional care, the risk of developing pressure sores, continence needs and mood and behaviour.

In the sample of care plans reviewed there was evidence care plans were updated at the required intervals or in a timely manner in response to a change in a resident's health condition. There was good linkage between assessments completed and developed plans of care.

The majority of care plans were well personalised. Care plans described well residents level of independence and what they could do for themselves. The risk assessments completed were used to develop care plans that were person-centred, individualised and described the current care to be given. However, further work is required to develop

care plans that are more person-centred and individualised for resident with dementia or behaviours that challenge. Care plans for residents with dementia did not identify where the resident is on their dementia journey. Information such as who the resident still recognised or what activities could still be undertaken to guide staff practice was not always evident.

There was limited documentary evidence that residents or their representative were involved in the development and review of their care plan. The discussion of the care plan was not detailed in narrative format outlining the resident's or their next of kin's agreement of the plans of care.

Residents admitted for short term care did not have a discharge care plan completed to guide staff in their rehabilitive goals and ensure a safe discharge.

There were two with wounds being dressed and one resident with a post surgery dressing. Care plans, wound dressing records and comments on progress were available. All wounds were indicating signs of improvement or had healed.

Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. Medical records evidenced residents were seen by a GP within a short time of being admitted to the centre. The GP's reviewed and re-issued each resident's prescriptions every three months. This was evidenced on reviewing medical files and drug cards.

Access to allied health professionals to include speech and language therapist and dietician were available to residents. The provider has employed a physiotherapist for three hours each week. The physiotherapist is available to review all residents and assist completing moving and handling risk assessment for new admissions. Some residents have a personalised exercise programs developed.

Nutritional screening was carried out using an evidence-based screening tool. There were five residents on a pureed diet and between 13 and 15 on a minced or moist diet. Staff recorded daily resident's food and fluid intake.

The policy of the centre is all residents are to be weighed at a minimum on a monthly basis. However, there were gaps in the records as a number of residents were not weighed consecutively each month. Sixteen residents were not weighed in January. While one resident's body mass index (BMI) indicated the resident was overweight a plan of care for intentional weight loss management was not in place.

There were opportunities for residents to partake in activites. An activity coordinator was employed for whole time equivalent role of 1·4. The inspector met with both activity coordinators and reviewed the activity schedule.

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

Findings:
There was an end-of-life care policy detailing procedures to guide staff. The policy of the centre is all residents are for resuscitation unless documented otherwise.

A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. There were 20 residents with a do not resuscitate DNR status in place.

However, a system was not developed to ensure residents with a DNR status in place have the DNR status regularly reviewed to assess the validity of the clinical judgement on an ongoing basis.

Each resident did not have a plan of care for end-of -life. Only residents with a DNR status in place had an end of life care plan. Resident's preferences with regard to transfer to hospital if of a therapeutic benefit, personal or spiritual wishes for end of life care were not documented for all residents.

Judgment:
Non Compliant - Moderate

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):

Findings:
There was evidence of a good communication culture amongst residents, the staff team

and person in charge.

Residents were well dressed. Personal hygiene and grooming were well attended to by care staff. The inspector observed staff interacting with residents in a courteous manner and respecting their privacy at appropriate times.

CCTV (closed circuit television) was in operation throughout the building. A notice was on display inside the main entrance. CCTV cameras were located in the day sitting room where residents spent their entire day and would have a reasonable expectation for privacy while in a communal area for example, while having their meals or spending time with their visitors. However, notices alerting residents and visitors to CCTV recordings were not in all areas where cameras were placed.

The use of communal areas requires review to ensure sufficient space for residents to meet their personal, social and recreational. While there were three day sitting rooms they were not adequately utilised to ensure suitable sitting, dining and recreational space for all residents The upstairs sitting room is used as both a sitting and dining room. At the time of this inspection 25 residents are accommodated on the first floor. Residents on the first floor did not go downstairs to the dining room during the day.

The organisation of the main communal sitting room on the ground floor requires review to ensure that all residents could sit in comfort. The layout also impinges on privacy and on access to the television. Some chairs were located in the centre of the room which meant that other residents were looking at the backs of chairs and could not see the television with ease.

During the morning time no residents were facilitated to use the second sitting room on the ground. Residents did not occupy this sitting room till after 2:00pm. While choice was respected many residents did not leave their bedrooms until before lunch time on each day of the inspection.

Judgment:
Non Compliant - Moderate

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

Findings:
The inspector judged there was an adequate complement of staff with the proper skills and experience on each work shift to meet the assessed needs of residents at the time of this inspection, taking account of the purpose and size of the designated centre.

There are two nurses and a clinical nurse manager rostered each day of the week. There are 11 care assistants rostered each from 8:00am till 2:00 pm and thereafter eight care staff till night duty commences. There are two nurses and three care assistants rostered each night.

However, the deployment of care staff and assignment of work practices requires review. This is required to ensure all residents have access to the dining room and residents are facilitated to use all communal sitting rooms earlier in the day. Similarly the role of activity coordinators require review to support residents interests and activities when two coordinators are rostered on the same day.

Information available conveyed that staff had access to ongoing education and a range of training was provided. The inspector found that in addition to mandatory training required by the regulations staff had attended training on cardio pulmonary resuscitation, and medication management.

Judgment:
Substantially 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 report[1]

Centre name:	An Teaghlach Uilinn
Centre ID:	OSV-0000309
Date of inspection:	02/03/2016
Date of response:	14/04/2016

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 review to ensure a defined set of criteria are reviewed regularly and systemically. For example, the falls audit requires review to identify trends within the data collected and reviewed. The review did not assist to identify repeat falls by individual residents and there was no correlation between the times falls occurred and staff levels.
Similarly the system to oversee aspects of physical restraint managements (use of

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

bedrails and lap belts) requires review.

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:
Falls audit: The audit tool currently in use is updated to include data pertaining to time of fall, location of fall and corresponding staffing levels. The data obtained is analysed to find specific trends related to recurring falls specific to time, location, staffing levels and also repeated falls of a specific resident.

Restraint audit: Audit tool currently in use is updated to include the effect of restraint used, duration of use and use of restraint as enablers.

Currently the above mentioned process is being completed for data collected in 2015.

Proposed Timescale: 13/06/2016

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 for 2015 with copies made available to the residents or their representative for their information as required by the Regulations.

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:
Feedback surveys are done on an annual basis to evaluate services provided by the nursing home. On completion of the audits as previously mentioned a complete report of the annual quality and safety of care delivered to resident will be made available to residents and their representatives.

Proposed Timescale: 14/07/2016

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:
Only ten of the Schedule 5 polices were accessible to staff on the electronic system. There was no paper copy for staff to reference until all polices are accessible on the electronic system

3. Action Required:
Under Regulation 04(2) you are required to: Make the written policies and procedures referred to in regulation 4(1) available to staff.

Please state the actions you have taken or are planning to take:
All policies are made available on the electronic system and staff have been notified of the same.

Paper copy of the policies will be made available on each floor by 13/05/2016

Proposed Timescale: 13/05/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The restraint assessments were not reviewed at four monthly intervals. The documentation did not outline or describe well how the raised bedrail supported the resident and ensured an enabling function in each of the assessments reviewed.

4. Action Required:
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

Please state the actions you have taken or are planning to take:
As part of the quarterly reviews all restraint assessments are being reviewed in consultation with the resident and or the representative.

Proposed Timescale: 13/06/2016

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 to identify any contributing factors for example, changes to medication or onset of an infection or a pattern in risk leading to a fall by a resident.

5. 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:
All falls occurring at the centre are reported in the prescribed format on the electronic system and follow up assessments are updated to reflect the general wellbeing of the residents post fall.

We will ensure incident review of each fall is updated on the individual resident records to ascertain the causative factors and thereby reduce risk of future falls.

Proposed Timescale: 01/05/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Each resident's moving and handling needs were identified and available to staff at the point of care delivery. While the type of hoist to be used was identified the sling size was not detailed.

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

Please state the actions you have taken or are planning to take:
Physiotherapist providing services on-site is currently reviewing the existing manual handling requirements of individual residents. Any resident using hoist will be mentioned with the corresponding slings to be used.

Proposed Timescale: 13/05/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The number of fire drills completed require review to ensure all staff have the opportunity to participate to include staff only rostered for night duty. The drills did not record the scenario/type of simulated practice.
Records did not evidence simulated fire drills are undertaken to reflect a night time situation when staffing levels are reduced.
The fire drill records did not detail the time taken for staff to respond to the alarm or evacuate a zoned compartment.

There was no evaluation of learning from fire drills completed to help staff understand what worked well, identify any improvements required and share learning.

7. 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:
Fire drills will be carried out at night to ensure that all night staff are aware of the procedures in relation to responding and evacuation in case of fire. The plan is to carry out the evacuations twice annually (announced and unannounced)

Brief of the evacuation procedure will be documented including the details of the evacuation, time duration and learning outcomes.

The policy and procedure will be discussed with staff at regular staff meetings.

Proposed Timescale: 01/05/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal emergency evacuation plans were not developed for each resident. A risk assessment to identify the most appropriate aids suitable to residents capability to assist them safely evacuate in a timely manner both during the day and at night while resting in bed were not developed.

8. Action Required:
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

Please state the actions you have taken or are planning to take:
A training session with the fire training consultant with the nurses is organised for 13/04/2016.The training will focus on PEEP assessments for individual residents. PEEP assessment templates have be uploaded on the electronic system. Assessments will be completed for all residents post the training session by the allocated nurses.

Proposed Timescale: 30/05/2016

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:
Further work is required to develop care plans that are more person-centred and individualised for resident with dementia or behaviours that challenge.

Care plans for residents with dementia did not identify where the resident is on their dementia journey.

Information such as who the resident still recognised or what activities could still be undertaken to guide staff practice was not always evident.

9. 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:
Social care plans are currently done by the activities co-ordinators with inputs from residents and families. Each resident's individual choices, habits and preferences are recorded. The level of involvement of each resident in individual / group activities is also specified and regular notes are done post those sessions.

Proposed Timescale: Done, ongoing

Proposed Timescale: 14/04/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was limited documentary evidence that residents or their representative were involved in the development and review of their care plan. The discussion of the care plan was not detailed in narrative format outlining the resident's or their next of kin's agreement of the plans of care.

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

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

4-monthly care plan reviews are done in consultation with the resident and or their representative. For the upcoming review the details of the consultation will be inputted into the individual resident's records.

Proposed Timescale: 13/06/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in weight records as a number of residents were not weighed consecutively each month. Sixteen residents were not weighed in January. While one resident's body mass index (BMI) indicated the resident was overweight a plan of care for intentional weight loss management was not in place.

11. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
Weights are done on a monthly basis and also depending on individual circumstances. All weights for the current month are updated on to the resident records.

Weight management care plan for the above mentioned resident in place.

Proposed Timescale: Done, ongoing

Proposed Timescale: 14/04/2016

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents admitted for short term care did not have a discharge care plan completed to guide staff in their rehabilitive goals and ensure a safe discharge.

12. Action Required:
Under Regulation 25(4) you are required to: Discuss, plan for and agree a discharge with a resident and, where appropriate, with their family or carer, in accordance with the terms and conditions of the contract agreed in Regulation 24.

Please state the actions you have taken or are planning to take:
On admission of short term residents a brief discharge plan is discussed and developed by the nurses. This process is in place for all short term residents admitted to the centre.

Proposed Timescale: Ongoing

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 was not developed to ensure residents with a (DNR) status in place have the (DNR) status regularly reviewed to assess the validity of the clinical judgement on an ongoing basis.

13. 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:
As part of the care plan reviews currently taking place residents with DNR status in place will be reviewed. The review will be continued on a four monthly basis.

Proposed Timescale: 13/06/2016

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Each resident did not have a plan of care for end-of -life. Resident's preferences with regard to transfer to hospital if of a therapeutic benefit, personal or spiritual wishes for end of life care were not documented for all residents.

14. 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:
End of life care plan for all resident in our care will be completed by mid June 2016.

Proposed Timescale: 13/06/2016

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:

CCTV cameras were located in the day sitting room where residents spent their entire day and would have a reasonable expectation for privacy while in a communal area for example, while having their meals or spending time with their visitors. However,

Notices alerting residents and visitors to CCTV recording were not in all areas where cameras were placed.

15. 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:
More signage pertaining to CCTV monitoring of the centre will be put on display (day rooms and dining room)

Proposed Timescale: 16/05/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of communal areas requires review to ensure sufficient space for residents to meet their personal, social and recreational. While there were three day sitting rooms they were not adequately utilised to ensure suitable sitting, dining and recreational space for all residents.
The upstairs sitting room is used as both a sitting and dining room.
Residents on the first floor did not go downstairs to the dining room during the day.
During the morning time no residents were facilitated to use the second sitting room on the ground floor.
Many residents were observed not to leave their bedrooms until before lunch time

16. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

Please state the actions you have taken or are planning to take:
All residents are encouraged to come to the communal areas in the morning after the breakfast and morning care is over.
Activity co-ordinators are in the process of planning and implementing more activities/ group sessions in the morning in the second day room on the ground floor.

Residents upstairs are given the choice to come downstairs to the dining room if they choose to do so.

Consultations are being done currently with the residents, their representatives and advocacy group regarding their preferences and suggestions relating to the same.

Proposed Timescale: Done, ongoing

Proposed Timescale: 01/05/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The organisation of the main communal sitting room on the ground floor requires review to ensure that all residents could sit in comfort. The layout also impinges on privacy and on access to the television.

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:
Seating plan in the day room is being reviewed at present.
Residents are being encouraged to use the second day room to provide more space and comfort.

Proposed Timescale: 04/05/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The deployment of care staff and assignment of work practices requires review to ensure all residents have access to the dining room and residents are facilitated to use all communal sitting rooms earlier in the day.

The role of activity coordinators require review to support residents interests and activities when two coordinators are rostered on the same day

18. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Staff on duty encourage resident to use the day rooms in the mornings and promote having meals in the dining room.

A review of the current practices is being carried out at present. Upon completion of the review, it will be discussed with all staff members and any changes implemented as required.

Proposed Timescale: 03/06/2016