Health Information and Quality Authority
Regulation Directorate

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

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

Centre name:	Gowran Abbey Nursing Home
Centre ID:	OSV-0000232
Centre address:	Gowran, Kilkenny.
Telephone number:	056 772 6500
Email address:	info@gowranabbeynursinghome.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Gowran Partners T/A Gowran Abbey Nursing Home
Provider Nominee:	Finian Gallagher
Lead inspector:	Ide Cronin
Support inspector(s):	Louisa Power
Type of inspection	Announced
Number of residents on the date of inspection:	50
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
09 May 2017 09:40	09 May 2017 16:50

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

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

The provider has applied to accommodate a maximum of 51 residents who need long-term care. This is the same level of occupancy which the centre is currently registered to accommodate. The inspectors observed practices, the governance system, clinical and operational procedures and records required by regulation to inform decision making on this registration renewal application inspection. The person in charge and those participating in management were knowledgeable of the regulatory requirements.

They were committed to providing person-centered, evidence-based care for residents. Questionnaires from residents and relatives were received and the

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

The management team facilitated the inspection process and had all the necessary documentation available for inspection which was maintained in accordance with the legislation. Overall, the inspectors were satisfied that residents received a quality service and there was evidence of a good level of compliance, across a range of areas, with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland (2016). Staff of various grades understood the ethos and principles of person-centred care and generally there were sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. However staffing levels on night duty required review and simulated fire drills to reflect night time conditions were required. Some improvement was also required in relation to medicines management.

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

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

Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose was available in the centre and it consisted of the aims, objectives and ethos of the centre Its statement reflected the services which were to be provided for the residents. It contained all of the information required by Schedule 1 of the regulations.

It was evident that the statement of purpose was implemented in practice.

Judgment:
Compliant

Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
On the previous inspection it was found that clinical and non clinical audits had not been carried out for over a year. Therefore the quality of care and experience of residents

was not monitored effectively as deficits in practice were not identified and could not positively inform improvements in the safety and quality of care or the quality of life of residents. An annual review of the quality and safety of the service as required by legislation for 2015 was not available to inspectors or residents. These actions had been completed.

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

The inspectors reviewed audits completed by the management team. Some areas reviewed included medication management infection control, hygiene, menus and care planning. The person in charge and assistant director of nursing discussed improvements that were identified with staff and corrective action plans to address any deficits were outlined as observed by the inspectors. There was a quality and safety committee in place. Representatives from all disciplines attended these meetings as observed by inspectors. There was a reporting system in place to demonstrate and communicate the service was effectively monitored between the person in charge and the service provider. There were regular governance meetings also with the directors of the company which took place on a fortnightly basis.

There was evidence of consultation with residents and or their representatives in a range of areas, for example, care planning and review process, involvement in social and recreational activities and meals provided. Arrangements were in place to consult with residents about their experience of the service. There was a residents' committee that met regularly and the inspectors observed that the meetings gave them a forum to express their views and changes were made as a result of their opinions. Satisfaction surveys were completed in 2016. An annual review of the quality and safety of care had been completed for 2016 and it informed the service plan for 2017 which was focussed on care planning as observed by the inspectors.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:
The centre was managed by a suitably qualified and experienced nurse who held authority, accountability and responsibility for the provision of the service. It was observed that there was daily engagement in the governance, operational management and administration of the centre.

The person in charge facilitated the inspection and ensured that all the documentation required was available. She was assisted by her deputy who takes charge in her absence and oversees the delivery of care and supports the nursing and care staff. Varied aspects of care practice were discussed with her during the inspection including care planning and dementia care.

Throughout the inspection the person in charge demonstrated adequate knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland.

Judgment:
Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
There had been no periods where the person in charge was absent from the centre for 28 days or more since the last inspection. The person in charge was aware of the obligation to inform the Chief Inspector of any proposed absence of the person in charge.

Suitable arrangements were in place for periods of absence of the person in charge. The fitness of the assistant director of nursing to replace the person in charge in the event of an absence was determined through observation and discussion during the inspection.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
Inspectors found that systems were in place to protect residents from being harmed or suffering abuse. Residents were provided with support that promoted a positive approach to behaviour that challenges. A restraint-free environment was promoted.

On the previous inspection, not all staff had received mandatory training and care plans to support residents in the management of behaviour that challenges required improvement. These actions had been addressed.

There were organisational policies in place in relation to the prevention, detection, reporting and investigating allegations or suspicions of abuse. Training records confirmed that all staff had received training in relation to responding to incidents, suspicions or allegations of abuse. The person in charge had attained a 'train the trainer' qualification for safeguarding training in February 2017. Staff with whom inspectors spoke were knowledgeable of what constitutes abuse and of steps to take in the event of an incident, suspicion or allegation of abuse. Residents with whom inspectors spoke confirmed that they felt safe in the centre.

There were systems in place to safeguard residents' money. Complete financial records that were easily retrievable were kept on site in respect to each resident. The centre did not manage the money of residents on their behalf. Inspectors saw that an itemised record of charges made to each resident was maintained. There was a system in place to verify that residents receive services, which are billed directly to the provider who then charges the resident.

A policy was in place to support residents with behaviour that challenges. Training records confirmed that training was provided to relevant staff in the management of behaviour that is challenging. Care plans demonstrated that there were clear strategies in place to support residents with behaviour that challenges. Clear proactive and reactive strategies were outlined and staff demonstrated familiarity with plans and their implementation. There was evidence that strategies and plans were updated when circumstances changed. When an incident of challenging behaviour occurred, staff documented the incident and completed an Antecedent Behaviour Consequence (ABC) chart. Multi-disciplinary input was sought when appropriate.

There was also a policy and procedure in place for the use of restraint. While bedrails and lapbelts were in use, their use followed an appropriate assessment and appropriate alternatives were trialled prior to the use of restraint. A risk-balance tool was completed prior to the use of bedrails or lapbelt, a comprehensive care plan was developed and reviewed every four months or more frequently when circumstances changed. Records demonstrated that residents were monitored and observed regularly while a bed rail or lapbelt was in place.

Some residents were prescribed 'as required' psychotropic medicines to be administered for agitation. Records reviewed indicated efforts were made to identify and alleviate the cause of the resident's behaviour. Alternative measures were considered and implemented before the medicine was administered. The resident was monitored following the administration of the medicine and the monitoring was recorded. The use of 'as required' psychotropic medicines was reviewed regularly, in line with guidance issued by HIQA.

Judgment:
Compliant

Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Safe care and support

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

Findings:
Overall there was evidence that the providers were committed to protecting and promoting the health and safety of residents, staff and visitors.

There was a health and safety statement in place which was last reviewed in September 2016. This outlined general aims and objectives in relation to health and safety within the centre. The health and safety statement was augmented by a risk management policy. The risk management policy outlined broad safety statements, the procedures for recording, reporting and investigation of accidents, a range of centre-specific risk assessments, an assessment of each risk and the controls identified as necessary to reduce each risk. The risks identified specifically in the regulations were included in the risk management policy. There was evidence that risk assessments had been implemented in practice and were kept under continual review.

A comprehensive emergency plan was in place and covered events such as severe weather conditions, power outage and water shortage. A generator was available in the event of a power outage and had been serviced in March 2017.

Accidents and incidents were identified, reported on an incident form and there were arrangements in place for investigating and learning from accidents. Accidents and incidents were analysed and discussed at regular management team meetings. Trends were identified and measures were put in place to prevent recurrence.

Suitable fire equipment was provided throughout the centre. There was an adequate means of escape. Fire exits were unobstructed. The clear procedure for safe evacuation of residents and staff in event of fire was displayed in a number of areas. Fire records were comprehensive, accurate and easily retrievable. The fire panel and emergency lighting were serviced on a quarterly basis, most recently in March 2016. Fire safety equipment is serviced on an annual basis. Five fire drills had taken place in the previous 12 months and a description of the fire drill, duration, participants and any issues identified were recorded. Fire drills to simulate night-time conditions had not taken place to ensure that residents could be safely evacuated in an emergency. This is also referenced under outcome 18 Suitable Staffing.

Records of daily, weekly and monthly visual fire checks were made available to inspectors. These checks included inspection of the fire panel, escape routes, fire box and water tank. Staff demonstrated good knowledge in relation to fire safety and the procedure to follow in event of a fire. The training matrix indicated that all staff had received mandatory fire safety training in line with the regulations.

A personal emergency evacuation plan (PEEP) was seen to have been developed for all residents. The PEEP took into account the number of staff required to evacuate the resident, the ideal means and route of evacuation and the location of the resident.

A designated smoking room was provided for residents and each resident who smoked was individually assessed. The individualised risk assessments were adequate and there was evidence of the implementation of the identified controls. The risk assessments included assessment of the need for observation or supervision and were reviewed every four months or more frequency if a resident's condition changes. The smoking area was mechanically and externally ventilated, equipped with fire fighting and fire detection equipment, a means to raise the alarm, viewing pane, fire resistant furniture and a fire retardant apron.

The training matrix confirmed that all staff were trained in the moving and handling of residents. Staff demonstrated a good understanding of the use of the hoist and contemporary moving equipments. Lifting equipment was serviced in line with manufacturer's guidelines. Each resident had a personalised manual handling plan and staff who demonstrated comprehensive knowledge of each resident's personalised manual handling plan; this was evidenced in practice.

Infection control practices were guided by the centre's policy and associated procedures. There was a contract in place for the disposal of clinical waste and records were maintained of removal and transport. Hand washing and sanitising facilities were readily accessible to staff and visitors. Clinical staff stated that they had access to sufficient personal protective equipment such as aprons and gloves. There was evidence of a regular cleaning routine that adequately prevented against cross contamination.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
Residents were protected by the centre's policies and procedures for medicines management. However, improvements were required in relation to secure storage of medicines requiring refrigeration, documentation and management of medicines administered in a modified format, such as crushing.

There were written operational policies relating to the ordering, receipt, prescribing, storage, disposal and administration of medicines. The policies were made available to staff who demonstrated adequate knowledge of this document.

Medicines for residents were supplied by a local community pharmacy. Inspectors saw evidence that the pharmacist was facilitated to meet obligations to residents under relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Residents received regular personal pharmaceutical care from their pharmacist.

Medicines to be stored at room temperature were stored securely in a locked cupboard or dedicated trolley. The temperature of refrigerator containing prescribed medicines was noted to be within an acceptable range; the temperature was monitored and recorded daily. However, it was noted that the refrigerator containing prescribed medicines was not capable of being locked.

Handling, storage and management of medicines requiring additional controls was in accordance with current guidelines and legislation.

A sample of medication prescription and administration records was reviewed. Medication administration sheets identified the medicines on the prescription sheet and allowed space to record comments on withholding or refusing medicines. However, where medicines were administered in a modified form such as crushing, this was not individually prescribed on the prescription chart. In addition, the time of administration of medicines was not recorded, in line with guidance issued by An Bord Altranais agus Cnáimhseachais.

Records confirmed that appropriate and comprehensive information was provided in relation to medicines when residents were transferred to and from the centre.

Medication related incidents, near misses and errors were identified, reported and there were arrangements in place for investigating incidents. Learning from incidents was clearly documented and preventative actions were seen to be implemented.

A system was in place for reviewing and monitoring safe medicines management practices. The results of the most recent medicines management audits in were made available. The audits reviewed all aspects of the medicines management cycle and included input from the pharmacist and residents.

Medicines which were out of date or dispensed to a resident but no longer needed were stored in a secure manner, segregated from other medicinal products and are returned to the pharmacy for disposal.

Nursing staff had completed comprehensive medicines management training in 2016 and online training in 2017.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
The inspectors reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to HIQA as required.

Judgment:
Compliant

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

Theme:
Effective care and support

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

Findings:
Each resident's wellbeing was 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 were set out in an individual care plan, reflecting each resident's needs, interests and capacities. The care plan was drawn up with the involvement of the resident and reflected the resident's changing needs and circumstances.

At the previous inspection, there was limited documentary evidence of the involvement of the resident and their representatives in the development and review of care plans and there was inconsistent evidence that end of life wishes were discussed with all residents. These actions had been addressed.

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of general practitioners (GPs) were currently attending to the needs of the residents and an "out of hours" GP service was available if required. Records confirmed that residents were assisted to achieve and maintain the best possible health through regular blood profiling, medicines usage reviews and health promotion. Residents were referred as necessary to the acute hospital services and there was evidence of the exchange of comprehensive information on admission and discharge from hospital. In line with their needs, residents had ongoing access to allied healthcare professionals including psychiatry of old age, dietetics, speech and language, specialist tissue viability services and chiropody. The resident's right to refuse was respected.

A sample of electronic care plans was reviewed. There was evidence of a pre-assessment undertaken prior to admission for residents. After admission, there was a documented comprehensive assessment of all activities of daily living, including mobility, nutrition, communication, personal care, oral care, mood and sleep. There was evidence of a range of assessment tools being used and ongoing monitoring of falls, pain management, weight, mobilisation and, where appropriate, fluid intake. Each resident’s care plan was kept under formal review as required by the resident’s changing needs or circumstances and was reviewed no less frequently than at every four months. There was clear documented evidence that residents and their representative were involved and consulted in relation to the development and review of care plans.

Wound management was in line with national best practice. Wound management charts were used to describe the cleansing routine, emollients, dressings used and frequency of dressings. The dimensions of the wound were documented and photographs were used to evaluate the wound on an ongoing basis.

There were no residents in the centre in receipt of end of life care on the day of

inspection. Palliative care services were available to support residents and staff with symptom control, including pain management. Inspectors reviewed a sample of care plans relating to end of life and saw that each resident's individual end of life needs and wishes were discussed with the resident and their representatives, if appropriate. Care plans relating to end of life were individualised and outlined the resident's physical, emotional, social and spiritual needs. Each resident's wishes and preferences for care at end of life were clearly documented.

Judgment:
Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
On the previous inspection it was found that the complaints procedure was not accessible to residents. This had been rectified. The centre had an effective complaints management system in place, which included a complaints policy and procedure that meet the requirements of the regulations. The complaints procedure was clear and accessible to both residents and their families. This procedure was readily displayed in a prominent location in the centre.

Inspectors saw that a six point clear print pictorial poster was now provided in each bedroom on how to make a complaint. Complaints were also listed as an agenda item for resident / relatives meetings. Details of the Office of the Ombudsman were also included in the policy.

There was a complaints log that was used to record any complaints. The inspectors read a sample of complaints that had been received and found that issues raised had been appropriately responded to by the person in charge. Details recorded included the nature of any complaint, actions taken and the outcome of the complaint including the satisfaction level of the complainant with the investigation.

Judgment:
Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the

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

Theme:
Person-centred care and support

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

Findings:
On the previous inspection it was found that opportunities for meaningful engagement were not responded too and a resident was not aware of advocacy services available. These actions had been completed.

The inspectors found that residents were consulted regarding the planning and organisation of the centre. Choice was respected and residents were asked how they wished to spend their day. Control over their daily life was also facilitated in terms of times of rising or returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms.

The inspectors reviewed the minutes of resident meetings and records were maintained of issues raised by the residents at these meetings. It was clear that residents were individually given the opportunity to raise their own issues at these meetings. Residents were facilitated to exercise their civil, political and religious rights. Residents could attend mass in the centre on a daily basis. There were no restrictions on visitors and residents could meet visitors in private. On the day of inspection visitors were observed spending time with residents in the private spaces available. Voting rights were respected, and the activities coordinator outlined the arrangements in place.

The inspectors saw that residents had access to televisions and radios. Newspapers were widely available and the main news topics were discussed each day with residents. The inspectors observed many photographs of residents' activities and celebrations throughout the centre. There was a mens' shed and music session taking place on the day of inspection. Inspectors observed residents watching a DVD of the Christmas pantomime in which residents, families and staff played different roles.

There were opportunities for all residents to participate in activities. There was a structured program of activities in place which was facilitated by an activities coordinator, four days per week. An inspector spoke with the activities coordinator and found that she was very enthusiastic and dedicated to improving quality of life for residents. The inspector found that she had intimate knowledge of each resident and their past history in relation to their personal and working life.

She had completed life stories for residents. There was a planned activity programme in place which was reviewed regularly. In relation to residents with dementia there was

evidence of appropriate techniques such as life stories, sonas, reminiscence, poetry or music used to enhance communication. The inspectors were satisfied that the activity schedule provided for both cognitive and physical stimulation.

There were notice boards available throughout the centre providing information to residents and visitors. There was a monthly newsletter available which outlined forthcoming trips and what was on in the centre for each month. The activity coordinator outlined details of independent advocacy services that were available to the residents. There were no residents presently requiring the service. However, this information was available and referrals would be made on the resident's behalf if required.

The advocacy poster was also displayed in bedrooms as observed by inspectors. Residents told an inspector they were free to plan their own day, to join in an activity or to spend quiet time in their room. Residents told the inspector that breakfast times were at the resident's choosing, and could go on till the late morning some days. Residents choose what they liked to wear and the inspectors saw residents looking well dressed, which included jewellery and makeup. Residents told an inspector that a fashion show had been held recently in the centre and they had thoroughly enjoyed it.

Judgment:
Compliant

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

Theme:
Workforce

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

Findings:
There were appropriate staff numbers and skill-mix to meet the assessed needs of residents during the day, but night staffing levels needed to be revised. Inspectors reviewed a sample of records and observed that staff had up-to-date mandatory training. There was evidence of continuing professional development also to enhance clinical skills such as dementia care, end of life, infection control, responsive behaviours and health and safety. The inspectors observed staffing levels and the skill-mix on the days of the inspection and reviewed a sample of rosters provided.

The inspectors were satisfied that there were adequate staff numbers and skill-mix to meet the assessed needs of residents and the safe delivery of services during the day. However, inspectors observed that there were seven hours during the night where there were two nurses and one healthcare assistant on duty. Inspectors formed the view that three staff could not adequately meet the safety, care and welfare needs of the residents given that 28 residents were assessed as maximum dependency and 36 residents had a definitive diagnosis of dementia.

Inspectors reviewed the fire safety records and found that that fire drills which simulated night-time working conditions had not been carried out therefore it could not be demonstrated that residents could be safely evacuated with the current allocation of staff on night duty. It had also been highlighted by the management team to the board of directors that there was a deficit in relation to resources on night duty.This was discussed with the provider nominee at the feedback meeting.

Staff demonstrated to the inspector their knowledge in a number of areas for example, infection control, fire safety, adult protection and caring for residents with dementia or responsive behaviours. Staff who spoke with inspectors confirmed that they were well supported to carry out their work by the provider and person in charge. The inspectors observed that call-bells were answered in a timely way, staff were available to assist residents and there was appropriate supervision in the dining rooms and sitting rooms throughout the inspection day.

A daily communication system was established to ensure timely exchange of information between shifts and at other intervals during the day which included updates on the residents' condition. There was evidence of regular staff meetings taking place. The inspector observed that staff appraisals took place on an annual basis. Good supervision practices were in place with the nurses visible on the floor providing guidance to staff and monitoring the care delivered to residents.

Evidence of professional registration for nursing staff employed was available and current. The required Schedule 2 documentation was available for staff in a sample of files reviewed and there was a formal recruitment process that included an interview for all new staff employed. The person in charge assured the inspector that all staff were Garda vetted. The inspectors saw that all volunteers were Garda vetted and their roles and responsibilities were set out in writing as required by the regulations.

Judgment:
Non Compliant - Moderate

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:

Ide Cronin
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:	Gowran Abbey Nursing Home
Centre ID:	OSV-0000232
Date of inspection:	09/05/2017
Date of response:	25/05/2017

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 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:
Fire drills to simulate night time conditions had not taken place to ensure that residents could be safely evacuated in an emergency.

1. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency

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

procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Fire drills paying particular attention to simulating night time conditions will be practiced with night staff and the outcomes documented.

Proposed Timescale: 09/06/2017

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Where medicines were administered in a modified form such as crushing, this was not individually prescribed on the prescription chart.

The time of administration of medicines was not recorded, in line with guidance issued by An Bord Altranais agus Cnáimhseachais.

2. Action Required:
Under Regulation 29(5) you are required to: 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.

Please state the actions you have taken or are planning to take:
The medication documentation is under review to comply with NMBI guidance recording the time of medication administration. All modified medication will be individually prescribed.

Proposed Timescale: 30/06/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The refrigerator which contained prescribed medicines was not capable of being locked.

3. Action Required:
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

Please state the actions you have taken or are planning to take:
Prescribed medicines which require refrigeration are now stored in a lockable refrigerator.

Proposed Timescale: Complete

Proposed Timescale: 25/05/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were seven hours during the night where there were two nurses and one healthcare assistant on duty. Inspectors formed the view that three staff could not adequately meet the safety, care and welfare needs of the residents given that 28 residents were assessed as maximum dependency and 36 residents had a definitive diagnosis of dementia.

4. 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:
The staffing level at night time has been reviewed resulting in a second care assistant rostered from the 12th June 2017

Proposed Timescale: 12/06/2017