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:	Sheelin Nursing Home
Centre ID:	OSV-0000160
Centre address:	Tonagh, Mountnugent, Cavan.
Telephone number:	049 854 0414
Email address:	info@sheelinnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Sheelin Nursing Home Limited
Provider Nominee:	Russell Mellett
Lead inspector:	PJ Wynne
Support inspector(s):	Geraldine Jolley
Type of inspection	Unannounced
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
18 October 2017 09:30	18 October 2017 18:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 14: End of Life Care	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This report sets out the findings of an unannounced inspection, carried out by the Health Information and Quality Authority (HIQA). The centre can accommodate a maximum of 36 residents who need long-term care, or who have respite, convalescent or palliative care needs. At the time of this inspection there were 33 residents living in the centre. Three residents were accommodated for a period of respite or convalescent care with the remaining majority of residents residing in the centre on a continuing care basis.

The staffing levels on each work shift, skill mix and supervision arrangements were adequate to meet the needs of residents. During this inspection the person in charge demonstrated to inspectors that she had the necessary clinical knowledge, skills and management experience to fulfil the duties required by her role. She is supported by a clinical nurse manager.

The premises, fittings and equipment were clean, well maintained and decorated to a good, comfortable standard. The building was warm and there was a variety of

options at each mealtime for residents. Bedrooms are suitable in size and equipped to suitably meet residents' needs.

Care plans were developed to a good standard and give a good oversight of each resident's lifestyle. Changes in health needs were outlined well with interventions to address medical and mental health issues clear.

There was evidence of regular reviews by allied health professionals including speech and language therapist, dietician, occupational therapy and a chiropodist. The provider employs a physiotherapist who attends the centre weekly.

There is an ongoing training for the professional development of staff. Mandatory training required by the regulations for all staff was met and updated on an ongoing basis. Specialist training in relation to the care of the older person in areas such as dementia, nutrition and safe feeding practices was facilitated.

Ten outcomes were inspected on this visit. Six outcomes were substantially complaint with the regulation. Three outcomes were non-complaint moderate namely Notification of Incidents, Health Safety and Risk Management and End-of –Life- Care.

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 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):

Findings:
The governance structure and the management systems in the centre remain unchanged since the last inspection in February 2017. Accountability for the service is defined. There are developed reporting lines of communication at individual and team level reflective of the statement of purpose.

There is a manager to oversee the operational management and administration of the centre and support the person in charge. The post of the person in charge is full time and she is supported in her role by a clinical nurse manger also employed in a full time capacity.

The actions form the previous inspection has been satisfactorily completed. The systems to ensure clear clinical governance have improved since the last inspection. Previously the procedures to develop implement and review care planning required improvement This matter has been satisfactorily completed and is discussed in more detail in Outcome 11, Health and Social Care Needs.

The auditing programme on this inspection was well established with key performance indicators (KPIs) reviewed monthly and weekly. There was a monthly programme of audits that included residents' dependency levels, audits of falls, management of medicines, accidents/incidents, psychotropic and analgesic medicines, the use of restraint and the built environment. There was trending of the information to help establish any patterns or identify repeat incidents. A post falls assessment tool has been introduced since the last inspection to identify any possible contributory factor for example, changes to medicines or onset of infection or clearly identify repeat falls by a resident.

There was a residents and relative satisfaction survey undertaken in 2017. The feedback from the questionnaires was positive in their comments on the quality of the care

service provided. However, the structure of the questionnaire was noted to require review as the answers only required a yes or no comment. There were no open style questions asked to ascertain more detailed views on the quality and safety of care.

There was an annual review of the quality and safety of care completed for 2016 which included details of complaints received, the outcome of the residents and relatives questionnaire and details on the number and type of incidents that occurred over the year. However, the annual report requires further detail to provide a more comprehensive oversight of the service. Quality improvement initiatives were not identified for action within the report for the forthcoming year of 2017.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

Findings:
The person in charge of the centre was appointed in April 2016. The nominated person in charge holds a full-time post. She is a registered nurse and holds a current registration with the professional nursing regulatory body.

During this inspection she demonstrated to inspectors that she had the necessary clinical knowledge, skills and management experience to fulfil the role of the person in charge. She had a clear understanding of her responsibilities in regard to the regulations. She is supported in her role by a clinical nurse manager.

Mandatory training required by the regulations was updated since the last inspection. This was an area identified for improvement in the previous inspection report. Refresher training in safe moving and handling techniques, safeguarding and fire safety was completed by the person in charge.

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:
The policy of the centre is to train all staff annually on safeguarding matters. Staff spoken with could explain and describe examples of indicators of abusive situations. Staff were clear on reporting procedures within the line management structure in conversation with inspectors. All staff had completed refresher training on safeguarding during 2017.

The safeguarding policy reviewed is not sufficient to adequately guide and inform management and staff on best practice procedures in safeguarding in line with the Health Service Executive's National Policy on 'Safeguarding Vulnerable Persons at Risk of Abuse 2014. A notifiable adult protection incident which is a statutory reporting requirement to HIQA had been reported since the last inspection. A review in relation to safeguarding procedures for residents was undertaken to ensure learning and effective protocols are in place. The person in charge has developed a new protocol to record any unexplained skin integrity concerns to allow for documenting and investigating.

The policy on the use of physical restraint (bedrails and lapbelts) was based on the national policy. This included guidance on the use of restrictive procedures including risk assessment and ensuring that the least restrictive intervention was used for the shortest period possible. Staff continued to promote a reduction in the use of bedrails. The person in charge had developed and introduced a new risk assessment tool since the last inspection. The documentation evidenced alternatives were trialled with a professional interdisciplinary input to the decision to ensure it was in the best interest of the resident and their safety. Risk assessments were regularly revised and were supported with a plan of care for each resident with the bedrails raised. The person in charge discussed her plan to continue to promote a restraint free environment with each new admission to the centre.

Staff had received training in responsive behaviours with two sessions of training undertaken in February and September 2017. Other staff had completed training throughout 2016. Care plans for residents with responsive behaviours and dementia were well developed since the last inspection when it was identified they were generic as they described general good practice and not the specific needs of the resident.

Care plan for responsive behaviour and behavioural and psychological symptoms of dementia (BPSD) are now well personalised. The revised care plans detailed potential triggers which may cause an altered pattern in mood or behaviour by a resident and the intervention to minimise any escalation in responsive behaviour.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building. The internal and external premises and grounds of the centre appeared safe and secure. A fire safety register and associated records were maintained and precautions against the risk of fire were in place. Records confirmed that the fire alarm system and fire safety equipment including emergency lighting and extinguishers were serviced.

There were designated escape routes from each floor of the building to an external area. The centre's fire safety policy detailed progressive horizontal evacuation procedures. If necessary there were designated escape routes to an external area. There is an external fire escape stairs provided to facilitate residents accommodated on the first floor evacuate the building in an emergency situation.

The needs of the residents had been assessed to outline their evacuation requirements in the event of a fire occurring. Personal emergency evacuation plans (PEEP's) were developed for long term residents. These detailed both day and night time evacuation requirements and were well developed to take account of each resident's physical dependency and cognitive function in relation to their capacity to understand and follow safety instructions. However, respite residents accommodated at the time of this inspection did not have their evacuation needs assessed and documented.

All staff had completed refresher training in fire safety over the course of 2017. The training was facilitated by an external trainer and included demonstrations in the use of fire extinguishers. In house fire drills were completed by staff as required by the action plan of the previous inspection. There were two drills completed which were well attended by staff. The records detailed the scenario and staff response time. However, the frequency of fire drills requires review to ensure all staff are competent in the procedures to be followed in the case of a fire. Fire drill scenarios to reflect a night time situation when staff levels are reduced had not been undertaken. Some staff spoken with were not aware of residents (PEEP's) and where they were located.

There were procedures to undertake and record internal fire safety checks. Regular

checks of the fire extinguishers were undertaken to ensure they were in place and intact, the fire panel and automatic door closers were operational. Records were maintained evidencing the fire escape routes were checked. The fire alarm is now operated each week to ensure it is functioning correctly. This was matter identified for improvement from the last inspection.

Training records evidenced that staff had up-to-date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents' needs. Each resident's moving and handling needs were identified and available to staff at the point of care delivery. The type of hoist and sling size required was specified in risk assessments.

There were a number of environmental safety checks completed in relation to the building and services. The temperature of dispensing hot water outlets were checked routinely. Flushing of water points not in regular use to minimise the risk of Legionella was undertaken. Evacuation sheets fitted to beds were checked to ensure they were in place and in good condition.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe care and support

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

Findings:
Residents have a choice of pharmacist. A new system to mange each resident's medicines has been introduced since the last inspection. Medicines are delivered to the centre on a monthly basis by the pharmacist.

There was a medicines management policy in place which provided guidance to staff to manage aspects of medicines from ordering, prescribing, storing and administration. However, the policy for prescribing requires review for residents accommodated for respite care. The arrangements for the management of resident's medicine on admission for respite care requires review to ensure each resident has a valid prescription. Some prescriptions were transcribed and were not signed by the GP.

The prescription sheets reviewed indicated the maximum amount for (p.r.n) medicine (a medicine only taken as the need arises) and the route via which the medicine is required to be administered was indicated in all cases. This was an area identified for improvement from the action plan of the previous inspection.

Photographic identification was available on the prescription chart for each resident to ensure the correct identity of the resident receiving the medicine and to reduce the risk of error in the sample reviewed.

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

Medicines were being stored safely and securely in the clinic room which was secured. Medicines that required strict control measures were kept in a secure cabinet which was double locked. Nurses kept a register of controlled drugs. Controlled drugs were checked by two nurses at the change of each shift.

Judgment:
Substantially Compliant

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

Theme:
Safe care and support

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

Findings:
The inspector reviewed a record of incidents or accidents that had occurred in the centre and cross referenced these with the notifications received from the centre. Quarterly notifications had been submitted to HIQA as required. However, a statutory notification in relation to a safeguarding matter was not submitted to HIQA within the required three day timeframe as required by the regulations. This was discussed with the person in charge that even if an allegation of abuse or misconduct is investigated and found not to have occurred, it is still a requirement that any allegation of abuse or misconduct by staff is notified to HIQA within three days of the event occurring.

Judgment:
Non Compliant - Moderate

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

drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

Theme:
Effective care and support

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

Findings:
There were 33 residents in the centre during the inspection. The majority of the residents were residing in the centre for long term care and three residents were accommodated for a period of respite or convalescent care. There were seven residents with maximum care needs. Five residents were assessed as highly dependent and 16 had medium dependency care needs. Five residents were considered as low dependency. Eight of the residents had a diagnosis of either dementia, cognitive impairment or Alzheimer's disease.

On admission a comprehensive assessment of needs was completed. There was a documented assessment of all activities of daily living, including communication, personal hygiene, continence, eating and drinking, mobility, spirituality and sleep. 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. Risk assessments were regularly revised. There was good linkage between risk assessments and care plans developed.

The inspectors reviewed a range of care plans including those of a resident with complex mental health problems, residents identified with a nutritional risk and others with fluctuating behaviour. Care plans for residents with deteriorating health conditions and those with bedrails raised and residents admitted for short term care were also examined.The actions identified in relation to care planning from the previous inspection were all satisfactorily completed. A new system of care planning has been introduced. Care plans were updated at the required interval and reviewed to detail the recommendations of allied health professionals.

There were individualised care plans in place for each identified need. Care plans were developed to a good standard and give a good oversight of each resident's lifestyle. Changes in health needs were outlined well with interventions to address medical and mental health issues clear. Each resident had a person centred care plan developed to outline and detail their life history, and their psychosocial wellbeing. The person centred care plans were reviewed and updated to reflect changes in resident's care needs.

Arrangements were in place so that each resident's care plan was kept under formal review as required by the resident's changing needs or circumstances. These were reviewed no less frequently than at four-monthly intervals. The development and review of care plans was done in consultation with residents or their representatives. The evaluation of the care plan outlined the professional judgment of the planned care

pathway and its effectiveness.

Residents had access to general practitioner (GP) services and there was evidence of medical reviews at least three monthly and more frequently when required. However, residents admitted for short term care had variable access to GP services. In accordance with regulation 6 (1) and (2), an improvement in timely medical assessment and clinical reviews as residents' needs indicate is required in relation to residents admitted for respite or convalescent care. This was discussed with the person in charge and plans for improvement in this area had been identified and work initiated.

There was evidence of regular reviews by allied health professionals including speech and language therapist, dietician, occupational therapy and a chiropodist. The provider employs a physiotherapist who attends the centre weekly. The physiotherapist is available to review all residents and undertakes individual and group exercise to promote mobility, improve respiratory function and develops passive exercise regimes for more frail residents.

Where residents had specialist care needs such as mental health problems there was evidence in care plans of referrals and reviews with the mental health services. Referrals were made to the consultant psychiatrist to review residents and their medication. The person in charge had advocated on behalf of a resident with complex mental health difficulties by securing an admission to an acute unit. Residents identified at risk of developing pressure wounds had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions to protect skin integrity.

Judgment:
Substantially Compliant

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

Theme:
Person-centred care and support

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

Findings:
A system of advanced care planning to meet end-of- life care needs is well developed. Staff initiated discussions with residents and relatives to ensure that their wishes were documented.

The policy of the centre is all residents are for resuscitation unless documented otherwise. A number of residents have a GP documented do not attempt resuscitation

(DNAR) status in place.

A multi disciplinary approach was undertaken to include the resident where possible, their representative, the GP and the nursing team. Relatives were consulted to ascertain the wishes of residents who were cognitively impaired. End-of- life care plans recorded detail of personal and spiritual wishes to assist meeting social and psychological needs. Links were maintained with the community palliative care and they would see residents on referral from the GP if required.

Practical arrangements for end of life care and care after death were identified as requiring review to support the continued dignity of residents in accordance with their advanced end-of-life care plans. The option and consideration for other residents to pay their respects in the deceased person's room prior to removal by the undertaker should be provided.

Judgment:
Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:
Person-centred care and support

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

Findings:
There was a good emphasis on personal care and ensuring the physical care needs of residents were met. 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.

Residents were able to exercise choice regarding the time they got up. The care plans for residents described their daily preferred routine well. Some residents have a preference to get up early. Staff identified these residents to the inspectors and their care plans when examined detailing their morning routine. Similarly some residents retired to bed early in the evening or late afternoon due to frailty and the rationale was outlined in their plan of care.

Personal care was provided in bedrooms with doors closed. Breakfast took place at a leisurely pace throughout the morning until 10.30am. Residents were complimentary of

the food options at each meal time

On the last inspection, the role of the activity coordinator was vacant. A new activity coordinator is now employed. The inspectors met the activity coordinator who explained her role and confirmed is employed four days each week. Records were maintained on a daily basis of each resident's participation in social activity and their level of engagement. The activity coordinator supported a varied schedule of recreation. On the day of inspection residents were involved in baking buns in the afternoon. Residents spoken with were complimentary of the social program and confirmed they is always a variety of activities planned. However, the activity coordinator had not completed a training program to support her to develop a recreation program suitable to individual residents' capacity and life stage in particular residents with dementia or cognitive impairment.

Residents had access to an independent advocate. The advocate had visited the centre to support residents in the recent past. Residents had access to radio, television in their bedrooms in addition to the sitting room and a variety of newspapers. An internal news leaflet tilted the 'Sheelin Herald' was published by the management team in June. This included a variety of information for residents on event planned in the centre, matters of local interest in relation to developments in the centre and photos of birthdays celebrated. As discussed in Outcome 2 Governance and Management the procedures to consult with residents and families require further development. While there were residents' meeting facilitated they did not occur routinely.

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

Findings:
The inspectors examined the staff duty rota, communicated with residents and relatives. During this inspection staffing levels on each work shift, skill mix and supervision arrangements were adequate to meet the needs of residents.

There are two nurses rostered during the day until 17.00hrs. In addition there is the person in charge who works full time over five days of the week. There are five care assistants rostered until 14.00pm and four in the afternoon and evening. In addition, there is an activity coordinator, catering and cleaning staff employed. The planned staff rota matched the staffing levels on duty. The sitting rooms and dining room were well supervised throughout the inspection. Call bells were placed within reach of residents who preferred to spend time in their bedroom during the day. Residents confirmed to the inspector's staff will respond when they use the call bell.

There was a policy for the recruitment, selection and vetting of staff. It was reflected in practice. Staff had the required qualities, skills and experience to undertake their duties associated with their role. Staff who communicated with the inspector confirmed that they were supported to carry out their work. Staff confirmed in conversations to the inspectors they undertook an interview, were requested to submit names of referees. Staff explained they commenced work after an induction period.

There is a training and development program to ensure that staff maintain competence in all areas relevant to their role. This includes specialist training in relation to the care of the older person in areas such as dementia, end-of-life care, nutrition and safe feeding practices. Mandatory training required by the regulations for all staff was met and updated on an ongoing basis. A sample of staff files from each role was reviewed. The files contained all documentation required under Schedule 2 of the regulations. There was evidence of vetting by An Garda Síochána for all staff.

Nursing staff were facilitated to engage in continuous professional development and had completed training on the management of medicines. Attendance at cardio pulmonary resuscitation training was facilitated. Training in continence care was planned for staff by a continence care nurse.

A staff appraisal system is in place in line with the policy on recruitment and selection of staff. However, only eight care staff have had their appraisal completed during 2017. Some new staff to include nurses did not have an appraisal undertaken since commencing employment to review their performance and professional competency.

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:	Sheelin Nursing Home
Centre ID:	OSV-0000160
Date of inspection:	18/10/2017
Date of response:	22/11/2017

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 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 annual report requires further detail to provide a more comprehensive oversight of the service. Quality improvement initiatives were not identified for action within the report for the forthcoming year 2017.

1. Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that

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

such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
The annual report will be reviewed and redeveloped to provide a more comprehensive over sight of services provided. The new format will reflect the quality improvements initiatives, it will be detailed and informative, it will also highlight future action plans.

Proposed Timescale: 31/12/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The structure of the residents and relatives questionnaire was noted to require review as the answers only required a yes or no comment. There were no open style questions asked to ascertain more detailed views on the quality and safety of care.

2. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
The structure of the questionnaire will be reviewed and redeveloped; more open style questions will be included to gather better feedback and determine more detailed views of both residents and families. A resident meeting with an invited representative from SAGE has been organised on 20Th November 2017 to provide an advocacy service to residents. This service from SAGE will be carried forward to future residents meetings. Questionnaires are planned to be sent to relatives 27th November 2017. A family forum meeting will be organised when questionnaires have been returned.

Proposed Timescale: 27/11/2017

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 safeguarding policy reviewed is not sufficient to adequately guide and inform management and staff on best practice procedures in safeguarding in line with, for example, the Health Service Executive's National Policy on 'Safeguarding Vulnerable Persons at Risk of Abuse 2014'.

3. Action Required:

Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
The safe Guarding policy will be reviewed and redeveloped in line with HSE national policy for vulnerable persons at risk of abuse 2014 in order to adequately inform management and staff on best practice procedures in safe guarding. The new policy will be integrated in Safe guarding training (SOVA) to ensure all staff are orientated and trained in accordance with our safe guarding policy. A safe guarding plan will be introduced with the policy.

Proposed Timescale: 30/11/2017

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The frequency of fire drills requires review to ensure all staff are competent in the procedures to be followed in the case of a fire. Fire drill scenarios to reflect a night time situation when staff levels are reduced had not been undertaken. Some staff spoken with were not aware of residents (PEEP's) and where they were located.

4. 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:
Drills are planned to be more frequent with more diverse mock scenarios - including night drills. Staff are now all oriented to fire procedures and evacuation plans (PEEP)

Proposed Timescale: 22/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Respite residents accommodated at the time of this inspection did not have their evacuation needs assessed and documented.

5. 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:
All respite residents have now their PEEP included in their individual folders and the master Evacuation and Emergency plan.

Proposed Timescale: 22/11/2017

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:
The arrangements for the management of resident's medicine on admission for respite care requires review to ensure each resident has a valid prescription .Some prescriptions were transcribed and were not signed by the GP.

6. 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:
We are currently in discussion with one of our GP's who manages the majority of residents to take on the role of medical officer for respite residents.

Proposed Timescale: 22/11/2017

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A statutory notification in relation to a safeguarding matter was not submitted to HIQA within the required three day timeframe as required by the regulations.

7. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
All notifications will be sent in the correct time frame via portal / post. Time frames have been highlighted, portal revisited and is accessible.

Proposed Timescale: 22/11/2017

Outcome 11: Health and Social Care Needs

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents admitted for short-term care had variable access to GP services. In accordance with regulation 6 (1) and (2), an improvement in timely medical assessment and clinical reviews as residents' needs indicate is required in relation to residents admitted for respite or convalescent care.

8. Action Required:
Under Regulation 06(2)(a) you are required to: Make available to a resident a medical practitioner chosen by or acceptable to that resident.

Please state the actions you have taken or are planning to take:
We are currently in discussion with one of our GP's who manages the majority of residents to take on the role of medical officer for respite residents. Currently if we have any health concerns for respite residents an appointment is made for them to see their own GP in the surgery where possible.

Proposed Timescale: 22/11/2017

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:
Practical arrangements for end of life care and care after death were identified as requiring review to support the continued dignity of residents in accordance with their advanced end-of-life care plans.

9. Action Required:
Under Regulation 13(2) you are required to: Following the death of a resident make appropriate arrangements, in accordance with that resident's wishes in so far as they are known and are reasonably practical.

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

Practical arrangements for end of life care are now in place to support continued dignity. Staff will be given training in end of life care.

Proposed Timescale: 22/11/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The procedures to consult with residents and families require further development. While there were residents' meeting facilitated they did not occur routinely.

10. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
Residents meetings are planned to be more frequent and will occur routinely. An invited representative from SAGE will attend a planned meeting on 20th November 2017. Relative questionnaires are currently under review with a plan to be sent on 27th November 2017. When the results of the questionnaire have been complied we plan to hold a relative forum meeting. This will carry through to 2018.

Proposed Timescale: 31/12/2017 – 31/01/2018

Proposed Timescale: 31/01/2018

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The activity coordinator had not completed a training program to support her to develop a recreation program suitable to individual residents' capacity and life stage in particular residents with dementia or cognitive impairment.

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

Please state the actions you have taken or are planning to take:
Activity coordinator will be given training to support and develop a suitable recreational programme for residents especially with dementia or cognitive impairment. She has

been to attend the next scheduled Activities coordinators programme she will also attend the PALS workshop at the next available date. Until she has completed both she will be trained, supported and guided by a member of staff who has completed activities coordinator, social activity training, Sonas apc and PALS workshop.

Proposed Timescale: 31/01/2018

Proposed Timescale: 31/01/2018

Outcome 18: Suitable Staffing

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Only eight care staff have had their appraisal completed during 2017. Some new staff to include nurses did not have an appraisal undertaken since commencing employment to review their performance and professional competency.

12. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
We have employed the services of an external HR company since May 2017, they have supplied us with a comprehensive staff appraisal form and timetable. We have implemented a new induction process for all new staff.

Proposed Timescale: 22/11/2017