

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Sunhill Nursing Home
<b>Centre ID:</b>	OSV-0004450
<b>Centre address:</b>	Blackhall Road, Termonfeckin, Louth.
<b>Telephone number:</b>	041 988 5200
<b>Email address:</b>	Shane@sunhill.ie
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	LSJ Care Ltd
<b>Provider Nominee:</b>	Shane Kelly
<b>Lead inspector:</b>	Una Fitzgerald
<b>Support inspector(s):</b>	Leanne Crowe
<b>Type of inspection</b>	Announced
<b>Number of residents on the date of inspection:</b>	68
<b>Number of vacancies on the date of inspection:</b>	2

## 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: 14 November 2017 10:00 To: 14 November 2017 19:30

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

<b>Outcome</b>	<b>Our Judgment</b>
Outcome 01: Statement of Purpose	Compliant
Outcome 02: Governance and Management	Substantially Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Substantially Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Compliant

**Summary of findings from this inspection**

This report sets out the findings of an inspection carried out to inform a decision for the renewal of the centre's registration.

During the course of the inspection, the inspectors met with residents and staff, the person in charge, the provider nominee and members of the management team. The views of residents and staff were listened to, practices were observed and documentation was reviewed. Surveys completed by residents and their relatives or representatives were also reviewed.

The inspector found that care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way. The provider nominee and person in charge had proactively engaged with all stakeholders to ensure that the culture within the centre was open and transparent. The management team responsible for the governance, operational management and administration of services and resources demonstrated good knowledge and an ability to meet regulatory requirements.

The management and staff of the centre strived to continuously improve residents' outcomes. A person-centered approach to care was observed. Residents appeared

well-cared for and expressed satisfaction with the care they received. There was good evidence that independence was promoted and residents had autonomy and freedom of choice. Residents spoke highly and positively about the staff who cared for them.

There was evidence of consultation with residents and their representatives in a range of areas on a daily basis and a formal resident meeting was held regularly. The centre had employed a second activities team member since the last inspection and this had a very positive impact on residents' daily lives.

The action plan from the last inspection in April 2017 was followed up. Overall, the inspector was satisfied that actions had been completed. However, two actions which were progressed but not completed are restated at the end of this report. These relate to clinical risks and environmental improvements to enhance way finding for people with dementia

During this inspection a judgment of moderate non compliance was found in one of the eight outcomes inspected. The findings are discussed in the body of the report and improvements are outlined in the Action Plan at the end for response.

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 detailed the aims, objectives and ethos of the centre. It outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the regulations.

The provider nominee and person in charge understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

The centre is currently in the process of applying to increase bed capacity within the centre and the Statement of Purpose with the required changes is ready for submission.

**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):**

**Findings:**

There were sufficient resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability, and the management team's roles and responsibilities for the provision of care are unambiguous.

The centre was managed by a suitably qualified and experienced nurse. The person in charge was in position since the last registration inspection in the centre and held authority, accountability and responsibility for the provision of the service. During the inspection she demonstrated that she had good knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre.

Staff and residents were familiar with current management arrangements. Residents were complimentary of the management team, telling the inspector that staff were approachable and receptive to new ideas. Staff knew the residents well and discharged their duties in a respectful and dignified way.

A comprehensive auditing schedule and review system was in place to capture statistical information in relation to resident quality outcomes, operational matters and staffing arrangements. Policies and procedures were in place to guide practice and service provision. An annual review of the quality and safety of care delivered to residents for 2016 was completed that informed the service plan being implemented in 2017. The annual review will be due for renewal in February 2018.

The provider nominee has responsibility for another centre but is based four days per week in this centre and so is available to support the person in charge and the nursing management team. The team meet formally every quarter and have rolling items on the agenda that address all areas of care delivery within the centre. The minutes of these meetings were reviewed by the inspectors.

A low level of complaints from residents and relatives was recorded. Inspectors reviewed the documentation and found that the management of complaints was in line with regulatory requirements and that all appropriate steps had been taken by management to ensure a satisfactory outcome. Interviews with residents during the inspection and satisfaction surveys completed by or on behalf of residents in preparation for this announced inspection were extremely positive in respect to staff, the provision of the care, the facilities and the overall service provided.

The inspectors followed up on the action plan from the previous inspection carried out in April 2017. While significant progress has been made in some areas, the inspectors were not satisfied that all actions had been completed. The inspectors are restating two actions for follow up from the last inspection. The first is discussed under Outcome 11 Health and Social Care needs. The second action that is restated was in relation to safe and suitable premises. As per the action plan response the centre was to ensure that extra signage be installed to help residents guide their way around the corridors. In addition, the centre was to repaint corridors with different contrasting colors. The inspectors were reassured by the provider nominee that these outstanding issue will be addressed with a time frame for completion in the action plan response at the end of this report.

**Judgment:**

Substantially Compliant

***Outcome 07: Safeguarding and Safety***

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

**Theme:**

Safe care and support

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

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

**Findings:**

Actions had been identified at the previous inspection in relation to safety checks in relation to bedrails, evidence of consent for use of restraint and the development of care plans in relation to responsive behaviours. Inspectors found that these actions had been completed on this inspection.

Inspectors found that there were systems in place to safeguard residents from being harmed or suffering abuse. There was a policy and procedure for the prevention, detection and response to abuse. Appropriate action was taken in response to allegations, disclosures or suspected abuse. Records indicated that all staff had received up-to-date training in the prevention, detection and response to abuse. Staff who spoke with inspectors were knowledgeable of their training and could describe what they would do in the event of an allegation, suspicion or disclosure of abuse. Residents told inspectors that they felt safe in the centre. The person in charge told inspectors that all staff in the centre had An Garda Síochána vetting disclosures in place, and evidence of this was provided on the day of the inspection.

A restraint-free environment was promoted in the centre. On the day of the inspection, some residents were using forms of restraint such as bedrails, and these were clearly documented in the centre's restraint register. Inspectors saw that risk assessments had been completed for residents using a form of restraint and there was evidence that consent had been obtained prior to implementation. Restraint use was documented in residents' care plans and was regularly reviewed to ensure it was necessary. There was evidence that safety checks were completed when bed rails were in use, which had been identified as an action in the previous inspection. There was evidence of alternatives to restraint being trialled or used where possible.

There was a policy and procedure in place for managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Due to their complex medical conditions, some residents showed responsive behaviours. Inspectors

saw that assessments had been completed and these had been used to inform the development of care plans for each resident that required one. Inspectors found that appropriate interventions had been consistently recorded in these care plans. Staff who spoke with inspectors were aware of possible triggers of responsive behaviours for residents and could describe the interventions that they would use.

The centre had a system in place for the management of residents' finances, which were being held securely. The provider acted as a pension agent for a small number of residents, and had recently engaged with an external auditor who found them to be compliant with guidelines issued by the Department of Social Protection. Comprehensive financial records that were easily retrievable were kept on site in respect to each resident. There was an itemised record of charges made to each resident, money received or deposited on behalf of the resident. Additionally, a small amount of money was managed on behalf of residents. Inspectors found that records were maintained for all transactions, and these were signed by two staff members and the resident where possible. Inspectors checked a sample of balances and these were found to correspond with the recorded transactions.

**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:**

Reasonable measures were in place to prevent accidents and incidents within the centre and its grounds. There was a risk management policy as set out in schedule 5 of the regulations and included all of the requirements of regulation 26(1). The policy covered the identification and assessment of risks and the precautions in place to control the risks identified. There was a risk register available in the center which covered for example, trip hazards and fire safety risks. Additionally, a comprehensive health and safety document had been developed in relation to the extensive building works that were taking place on the site of the nursing home at the time of the inspection.

There were adequate governance and supervision systems in place to monitor residents at risk of falls, wandering or negative interactions. Regular health and safety meetings took place where this information was reviewed and any actions were identified.

The fire policies and procedures were centre-specific and the fire safety plan was viewed by inspectors and found to be adequate. There were fire safety notices for residents, visitors and staff appropriately placed throughout the building. All staff had completed



up-to-date fire training and those who spoke with inspectors could outline what action to take in the event of a fire. A number of fire drills had recently been completed, and records of these detailed the amount of time taken to complete each drill, the staff who were involved and any resulting learning or actions. The person in charge confirmed that fire drills that reflected staffing levels at night and during the day had been completed. A traffic-light system was used throughout the centre to support staff to quickly identify the level of assistance residents would require to evacuate the building.

The inspectors examined the fire safety register which evidenced that services and fire safety tests were carried out in line with requirements. However, in records from a service completed by a competent person in January 2017, it was noted that recommendations were made in relation to fire extinguishers within the centre. Inspectors found that these recommendations had not been followed-up on by the provider or carried out at the time of the inspection. When this was brought to the attention of management on the day of the inspection, they confirmed that the recommendations made in relation to the fire-safety equipment would be reviewed. Emergency lighting throughout the centre was tested on a monthly basis and a daily check of fire exits and escape routes was carried out. These were evidenced in comprehensive records that were reviewed by inspectors.

A small number of residents who smoked could access a smoking room within the centre, which facilitated the supervision of residents if required. Inspectors found that individual smoking risk assessments were completed for all residents who smoked and appropriate safety measures were in place.

There was a policy and procedure in place in relation to infection control procedures. Staff had completed training in infection control practices, and inspectors saw that there were systems to support good infection prevention and control throughout the centre. Alcohol hand gel and adequate hand washing facilities were readily available and inspectors observed good hand hygiene practices throughout the day.

**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:**  
A medicines management policy was in place to inform safe medicines management practices in the centre. The inspector observed that residents' medicines were stored appropriately, including medicines controlled under Misuse of Drugs legislation and medicines requiring refrigeration. Checks were consistently completed of balances of

controlled medicines twice every 24 hours and refrigerator temperatures were recorded on a daily basis. An audit of medication management practices within the centre had recently been completed by the centre's pharmacy service, and inspectors found that any action identified had been completed or were in the process of being addressed.

The inspectors observed medicine administration to a number of residents on this inspection. The staff nurses administering medicines wore a red apron to alert others that they should not be disturbed during the procedure. Residents' medicines were administered on an individual resident basis and the inspectors observed that medicines were administered to residents in line with professional guidelines. Medicines administered by nurses in a crushed format were individually prescribed. Inspectors found that one resident was being administered their medications on a covert basis. This arrangement had been reviewed by a multidisciplinary team and had been signed off by the prescribing GP and clinical team as it was deemed to be in the resident's best interests. Inspectors noted that the administration of these medicines were reviewed on a regular basis and was being steadily decreased over time. However, the administration of covert medication was not being done in line with the centre's local policy, which was brought to the attention of management on the day of the inspection. It was agreed that this would be reviewed.

There were procedures in place to support a number of residents that were self-administering medicines. Records indicated that all residents self-administering had signed consent forms and were assessed on a regular basis.

There was a system in place for reporting and investigating medication errors or near misses. Inspectors reviewed these reports and found that any errors reported were investigated and actions were put in place to mitigate the risk of such errors reoccurring. Any learning from these reports were disseminated to all staff.

**Judgment:**

Substantially 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):**

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

**Findings:**

Residents' health care needs were met through timely access to medical services and

appropriate treatment and therapies. Arrangements were in place to meet the health and nursing needs of residents. Access to a general practitioner (GP) and allied healthcare professionals, including physiotherapy, occupational therapy, dietetic, speech and language, dental, ophthalmology and specialist palliative care services were made available when required.

Residents had good access to allied health care services. The care and services delivered encouraged health promotion and early detection of ill health, which facilitated residents to make healthy living choices. There was evidence within the files that advice from allied healthcare professionals was acted on. For example, a dietician had made three new recommendations within one resident file. The inspectors reviewed the care plan and the advice was followed as per recommendations. The GP had reviewed the resident and altered the prescription. The chef was able to inform the inspector's of the residents specific dietary needs and was aware of the changes made.

Pre-admission assessments were carried out and recorded for all residents that were admitted for long term care. Residents that are admitted for respite are not routinely met with prior to admission. The person in charge communicates with the referring service and ascertains by phone if their care needs can be met within the centre. The person in charge confirmed that to date this process has proved effective. There were processes in place to ensure that when residents were admitted, transferred or discharged to and from the centre, relevant and appropriate information about their care and treatment was maintained and shared between providers and services.

On admission all residents have an assessment of their care needs carried out. Each resident had a personalised holistic care plan prepared within 48 hours of their admission which detailed their needs and choices. Of the files reviewed the inspector noted a number of gaps that were discussed at the feedback meeting. For example: the falls risk assessment and care plan of one resident that was admitted post a history of falls had not been carried out for four days post admission.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. The management of pain assessment and documentation required review. For example, one resident with multiple sites of pain that receives regular analgesia did not have any pain assessment on file or a care plan directing staff on how best to manage the pain when reported.

As per the last inspection the centre use a traffic light system with colour and symbols that identify residents falls risk, emergency response interventions and evacuation methods. The inspector spoke with staff and some were unable to explain to the inspector the meaning of the symbols. This action is restated from the last inspection. The inspector cross referenced the symbols on the doors with the information in the care plans. Of the files reviewed, the inspector found symbols that required updating. This was communicated to the management team who agreed to carry out a review of the symbols.

The inspectors also requested a review of the ease of retrieval of key clinical information on residents wishes in the event of a cardiac event. All files reviewed did have the resuscitation status documented within their file. However, this information is kept at

multiple locations. The inspectors were informed that this issue will be addressed by the upgrade due on the electronic system in place.

Overall, inspectors found that care plans were person centered. Although some gaps were identified as previously discussed, the inspectors did find that all care plans were reviewed and evaluated in partnership with the resident or relative, at intervals not exceeding four months as per the regulations. The inspectors spoke with residents who were familiar with care plans. The residents also confirmed that they were consulted with on any changes that are recommended.

**Judgment:**

Non Compliant - Moderate

***Outcome 16: Residents' Rights, Dignity and Consultation***

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

Residents' views were welcomed and residents were consulted in relation to the running of the centre. Resident meetings are held regularly and minutes reviewed showed good attendance. Open discussions are held on how the building should be decorated for significant events such as Halloween and Christmas, as evidenced within the minutes. Surveys completed by residents and their relatives or representatives were also reviewed. The feedback in relation to the activities schedule was extremely positive.

Residents responded positively to staff interactions. Staff skilfully engaged and reminisced with residents using information they knew about their interests, families and friends. Inspectors found that the atmosphere was warm, engaging and friendly. Since the last inspection the centre had employed a second activities team member.

Significant progress has been made into how each resident is given the opportunity to participate in meaningful and purposeful activity that suits their individual needs and interests. The staff described and files evidenced one to one activities that occur for residents that do not wish to attend group activities. The activities team have recently completed a Life story for all residents that wished to be involved. The Life story captures very specific detail on each resident and is framed in their bedroom. The activities team have also recently completed a Make a Wish day for all residents. This initiative involved multiple day trips out for residents to visit places of significance to them. Inspectors felt that the centre places huge importance into the activities

schedule. The residents have had multiple opportunities to go on organised outings. The inspectors spoke with two residents who spoke about the holiday that was organized for last August and about how it was enjoyed by all.

Residents have access to an independent advocacy service. The centre is part of the local community and residents have access to radio, television, newspapers and information. Residents are facilitated to exercise their civil, political and religious rights. There are arrangements for residents to receive visitors in private.

Staff are aware of the different communication needs of residents. Interventions to support residents with specific communication requirements are accommodated. For example, the use of electronic equipment. Inspectors reviewed communication care plans and found sufficient detail to guide the team on how best to communicate with residents.

**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):**

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

**Findings:**

Inspectors found that there were appropriate staff numbers and skill-mix on duty to meet the assessed clinical and social needs of residents. There was one action identified at the previous inspection in relation to an appraisal policy and inspectors found that this had been completed at the most recent inspection.

On the day of the inspection, an actual and planned staffing roster was in place and reflected the actual number of staff on duty. Any changes to the roster were clearly indicated. Staff were observed responding to residents' needs and requests quickly, and residents were well-supervised throughout the day. Residents spoke very positively about staff to inspectors, and interactions between staff and residents were observed to be kind, friendly and respectful throughout the day of the inspection.

There were policies in place for the recruitment, selection and vetting of staff and also staff training and development. A sample of staff files were reviewed by inspectors and

these were found to contain all of the information required by Schedule 2 of the regulations, including An Garda Síochana vetting disclosures. Inspectors reviewed records confirming that all nursing staff were registered with An Bord Altranais agus Cnáimhseachais na hÉireann.

Procedures were in place for the induction of newly recruited staff which included training and supervision. The person in charge explained to inspectors that appraisals were completed at three and six months following recruitment, and all staff participated in an annual appraisal thereafter. Evidence of these appraisals were reviewed by inspectors.

Training records were provided to inspectors and indicated that all staff had completed up-to-date training in safe moving and handling practices, fire safety and the prevention, detection and response to abuse. A large portion of staff had also completed training in restrictive procedures, wound care, infection control and responsive behaviours. Staff spoken with by inspectors were knowledgeable regarding the training that they had completed. The person in charge told inspectors that staff were supported to maintain their professional development and skills.

There were no volunteers operating in the centre at the time of the inspection but management were aware of their responsibilities in relation to the use of volunteers.

**Judgment:**  
Compliant

## Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

### Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

### *Report Compiled by:*

Una Fitzgerald  
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<sup>1</sup>

<b>Centre name:</b>	Sunhill Nursing Home
<b>Centre ID:</b>	OSV-0004450
<b>Date of inspection:</b>	14/11/2017
<b>Date of response:</b>	29/11/2017

### 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 inspectors followed up on the action plan from the previous inspection carried out in April 2017. As per the action plan response the centre was to ensure that extra signage be installed to help residents guide their way around the corridors. In addition the centre was to repaint corridors with different contrasting colours. The inspectors were reassured by the provider nominee that this outstanding issue will be addressed with a time frame for completion stated.

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

**1. Action Required:**

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

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

1. Sunhill has an ongoing painting program in progress –as soon as the painters are finished in the new extension they will be moving into the existing building.
2. Extra signage to all areas within the new and existing building will be in place for December 19th 2017.

Proposed Timescale:

- (1) To be Completed fully by June 29th 2018
- (2) Completed December 19th 2017

**Proposed Timescale: 29/06/2018**

**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:**

Inspectors found that recommendations were made by a competent person in January 2017, in relation to fire extinguishers within the centre had not been followed-up on by the provider or carried out at the time of the inspection.

**2. Action Required:**

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

Listed fire extinguishers have been replaced with updated certification on display in main reception.

**Proposed Timescale: 24/11/2017**

**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 administration of covert medication to one resident was not being done in line with the centre's local policy.



### 3. 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:

- (1) Medication management policy has been reviewed to ensure that it reflects practice within the centre
- (2) The practice in relation to this individual resident has been reviewed with their family and the appropriate documentation is in place.

#### Proposed Timescale:

- (1) completed 27th Nov 2017      (2) completed 29th Nov 2017

#### Proposed Timescale:

## 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:

The management of pain assessment and documentation required review. For example, one resident with multiple sites of pain that receives regular analgesia did not have any pain assessment on file or a care plan directing staff on how best to manage the pain when reported.

### 4. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

- (1) All residents who are receiving any form of regular analgesia have had their documentation reviewed to ensure appropriate pain management recording is in place.

#### Proposed Timescale: 01/12/2017

#### Theme:

Effective care and support

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

On admission all residents have an assessment of their care needs carried out. Each resident had a personalised holistic care plan prepared within 48 hours of their

admission which detailed their needs and choices. Of the files reviewed the inspector noted a number of gaps that were discussed at the feedback meeting. For example: the falls risk assessment and care plan of one resident that was admitted post a history of falls had not been carried out for four days post admission.

**5. Action Required:**

Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

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

(1) On full audit Sunhill has a very high compliance with documentation requirements, however in this case the PIC has reinforced with all Nurses the requirements of admission documentation within Regulation as well as our own Admission policy.

**Proposed Timescale:** 20/11/2017

**Theme:**

Effective care and support

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

As per the last inspection the centre use a traffic light system with colour and symbols that identify residents fall risk, emergency response interventions and evacuation methods. The inspector spoke with staff and some were unable to explain to the inspector the meaning of the symbols.

The inspector cross referenced the symbols on the doors with the information in the care plans. Of the files reviewed, the inspector found symbols that required updating.

**6. Action Required:**

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

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

(1) A huge amount of time has been spent reinforcing this information with staff over the last year – however we have now also placed strategically throughout all corridors explanation charts for the traffic light system to ensure all staff are constantly reminded of their meanings

(2) For more sensitive emergency response intervention labelling, these will be placed in staff room and staff changing areas to constantly remind staff of their meaning

**Proposed Timescale:** 08/11/2017

**Theme:**

Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement**

**in the following respect:**

The inspectors also requested a review of the ease of retrieval of key clinical information on residents wishes in the event of a cardiac event. All files reviewed did have the resuscitation status documented within their file. However, this information is kept at multiple locations.

**7. Action Required:**

Under Regulation 06(2)(b) you are required to: Make available to a resident medical treatment recommended by a medical practitioner, where the resident agrees to the recommended treatment.

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

- (1) An upgrade of Epiccare software in January 2018 will ensure that this key information is retrievable on the main screen for each resident.
- (2) In the mean time this information is being made available in paper form to all staff.

**Proposed Timescale:**

- (1) for completion 15th January 2018
- (2) completed 29th November 2017

**Proposed Timescale: 15/01/2018**