<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Castleturvin House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000327</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Athenry, Galway.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>091 850 800</td>
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<tr>
<td>Email address:</td>
<td><a href="mailto:castleturvinnh@gmail.com">castleturvinnh@gmail.com</a></td>
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<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Castleturvin Home Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Sweeney</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Amy Collins</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the</td>
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<td>Number of vacancies on the</td>
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About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

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 2 day(s).

The inspection took place over the following dates and times

From: 18 September 2019 08:00
To: 18 September 2019 16:30
19 September 2019 10:00
19 September 2019 16:30

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self-assessment</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Not applicable</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Not applicable</td>
<td>Non-Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Not applicable</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Not applicable</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Not applicable</td>
<td>Non-Compliant - Moderate</td>
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<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Not applicable</td>
<td>Non-Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td>Not applicable</td>
<td>Non-Compliant - Major</td>
</tr>
<tr>
<td>Outcome 08: Governance and Management</td>
<td>Not applicable</td>
<td>Non-Compliant - Moderate</td>
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Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspector focused on specific outcomes relevant to dementia care and followed up on the actions from the previous inspection completed in March 2019. Some of the actions from this inspection remained outstanding, including staff training and development, fire management systems, residents' rights and, governance and management. The provider representative, who is also the person in charge, and the assistant director of nursing facilitated the two-day inspection.
The Chief Inspector within HIQA had received unsolicited information regarding staffing levels and staff training and development, prior to the inspection. The concerns relating to this information were partially substantiated.

Inspectors met with residents, relatives and staff members and tracked the journey of residents with dementia within the service. Inspectors observed care practices and interactions between staff and residents with dementia using a validated observation tool. The inspectors also reviewed documentation such as care plans, medical records, staff rosters and training records.

The centre is registered to provide accommodation to 42 residents. There were 29 residents accommodated over the two day inspection, 15 of whom had a confirmed diagnosis of dementia or were showing symptoms of cognitive decline. The centre contained the Waldron unit, which was a secured unit accommodating up to six residents. There were three residents accommodated in the unit at the time of inspection. The staffing for the unit was shared with the designated centre. Two of the residents accommodated within the unit were assessed as having maximum dependency needs and one resident had highly complex needs and required maximum levels of supervision.

Overall, the health care and nursing needs of the residents were met to a high standard. Residents had timely referral and access to a wide variety of allied health professionals including dietetic services, speech and language therapy, physiotherapy, chiropody, and occupational therapy. All residents had an up-to-date comprehensive assessment completed and updated in line with regulatory requirements. Appropriate and person-centred care plans were in place for all residents. Residents with symptoms of dementia had their care planned in an evidence-based, respectful and sensitive manner. Care plans included the residents’ personal responses to external influences and how these responses could be managed in a safe and effective manner. Staff had access to the care plans and inspectors observed care to be delivered in line with the care plan.

Residents were observed to be comfortable and relaxed in the company of staff. Inspectors observed that staff communication with residents was kind and respectful at all times. Residents spoken with were complimentary and spoke highly of the staff. The registered provider had furnished and decorated the centre in a comfortable and appropriate manner. Extra fixtures and fittings had been sourced to ensure that the environment was familiar and restful for residents with a diagnosis of dementia.

While inspectors observed good practice in areas relating to maintaining a homely environment, nursing care and documentation: substantial poor practice and risk was found in areas relating to the training and development of staff, especially in relation to fire safety and in the governance and management of the centre.

Inspectors reviewed the training records of the staff and found that training received by staff in relation to fire safety, infection control and moving and handling was not provided by a suitably trained person and therefore not suitable to meet the needs of
the residents.

A walkway and conservatory that linked to the Waldron unit, which was observed by inspectors to be used regularly by residents, had not been registered as part of the designated centre. This was identified by inspectors as a risk to residents as the area was not connected to the fire alarm system of the centre.

CCTV (closed circuit television cameras) was used on all internal corridors and in the day rooms. The cameras were monitored by management and nursing staff. This impacted on the privacy of the residents and their visitors in areas of the centre in which privacy would be expected.

Inspectors found that complaints were well managed within the centre.

Inspectors found poor compliance in relation to fire management. An urgent compliance plan was issued the day after the inspection to address the immediate risks to the residents, staff and visitors.

The overall governance and management systems in the centre required review. The service was not well monitored. For example,

- poorly defined management structure
- audits lacked the information required to identify areas of improvements
- significant gaps found in staff training records
- significant gaps found in staff records

Areas of non-compliances and repeated non-compliances were communicated to the management team and are discussed in the main body of the report and set out in the action plan at the end of this report in order to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to assessment and care planning, access to healthcare, maintenance of records and policies. The centre uses an electronic system for clinical documentation.

Overall, inspectors observed that residents' health and social care needs were met to a high standard. Residents were enabled to make healthy living choices. Residents had access to health and social care services in line with their assessed needs. Individual assessments and person-centred care plans were in place for each resident.

Each resident had a pre-admission assessment on file which detailed the resident's personal care needs prior to admission to the centre. A comprehensive assessment of each resident was completed on admission, and reviewed every four months or as required, thereafter.

Care was observed to be delivered to the residents in line with their care plan. Care plans were based on evidence-based practice. Residents with a diagnosis of dementia had specific dementia care plans in place which identified the symptoms of dementia that were personal to the resident. The care plans included a description of triggers that would cause distress and anxiety to the residents, sometimes resulting in residents responding to staff or other residents in an agitated or aggressive manner. The residents' behaviour was detailed in a respectful and person-centred way. Staff had access to the care plans through an electronic documentation touchscreen system.

There was evidence of the involvement of the residents and their families in the development of care plans.

Arrangements were in place to meet the broader health and social needs of the residents with dementia. The centre had good access to two local doctor surgeries. The centre was visited weekly by a general practitioner (GP). There was good access to allied health professionals such as dietitian, occupational therapist, physiotherapist, chiropody and the psychiatry of later life. The recommendations from the allied health professionals had been documented in the resident's care plan. For example, following a review of a resident by a dietitian, the recommendations were recorded to the resident's
care plan. This information was communicated to the care and catering team ensuring a high standard of care was delivered. Meals were observed to be wholesome and nutritious and served in an appetising manner. Residents spoken to stated that they enjoyed the food provided.

An up-to-date policy was in place to monitor residents' nutritional intake. Residents who had been assessed as having a high risk of malnutrition had an appropriate and evidence-based care plan commenced. Residents' intake and weight was closely monitored. Care and catering staff demonstrated a clear awareness of residents with eating and drinking care needs. Water and snacks were freely available to residents at all times. Residents were assisted with eating and drinking in a discreet and sensitive manner.

Nursing staff advised the inspectors that there were no residents with wounds on the day of inspection. The assistant director of nursing confirmed that the centre had access to a tissue viability nurse specialist when required.

End-of-life care plans for residents with dementia were detailed, person-centred and respectful. An end-of-life policy was in place and staff were familiar with the procedures relating to end-of-life care. The centre had access to a specialist palliative care team.

Judgment:
Compliant

**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
An action from a previous inspection carried out in March 2019 relating to training staff in safeguarding had not been completed. According to the training matrix available for review on the day of inspection four staff members had not received training in relation to safeguarding vulnerable older persons from abuse. On further discussion with the person participating in management (PPIM) the inspector was not provided with the evidence of training, requested on the day of inspection.

The centre had policies in place in relation to the prevention, detection and response to abuse. Staff spoken with were aware of the procedures to be followed in relation to any allegation of abuse. The person in charge confirmed that An Garda Síochána (police) vetting was in place for all staff and persons who provided services to the centre. A sample of files reviewed confirmed this to be the case.
The inspectors were satisfied that the centre promoted a restraint-free environment. An up-to-date policy was in place in relation to the management of restraint in the centre. All physical restraints used were logged in a restraint register. The documents and the procedures in place were comprehensive and in line with regulatory requirements. Residents had free access to the outdoor enclosed gardens and were observed to move freely around the centre on the two days of inspection.

Residents spoken with said that they felt very safe within the centre. On review of the complaints and incident log, the inspectors identified a number of incidents relating to the alleged behaviour of one resident towards other residents. These behaviours were documented and appropriate interventions were developed and communicated to staff. However, the incidents were not notified to the Chief Inspector. This issue is addressed under Outcome 8, Governance and management.

The centre had systems and arrangements in place to safeguard residents' finances. The procedures and processes for safeguarding residents' finances were clear and transparent. The centre acts as a pension agent for three residents. This is managed within the guidelines outlined by the Department of Social Protection.

**Judgment:**
Non Compliant - Moderate

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**Outcome 03: Residents' Rights, Dignity and Consultation**

**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:**
Inspectors found evidence that residents were consulted and offered choice as part of the everyday culture in the centre. Resident forum meetings were held regularly and were well attended. Feedback was sought from residents and action plans were in place to address any issues discussed. Minutes of the meetings were reviewed. Residents with dementia were represented by an independent advocate. Residents had access to the services of an independent advocate. The residents guide detailed how residents could access the service.

Inspectors noted that the privacy and dignity of residents was well respected. Bedroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms.

Residents' political and religious rights were respected and facilitated. Residents had access to daily mass through a radio link to the local church. Residents were facilitated
The social activities scheduled in the centre were facilitated by the activity coordinator who had developed a person-centred activity plan for each resident. Staff reported that the shortage of staff had impacted the delivery and facilitation of the activity programme to the residents especially during the weekends. Residents were seen to be engaging and enjoying the activity programme on the day of inspection. A dementia specific therapy intervention was scheduled and inspectors observed residents with a diagnosis of dementia being encouraged and facilitated to engage in the therapy. Residents told inspectors that they enjoyed the activities provided by the centre and always had plenty to do during the day.

As part of the inspection, inspectors spent periods of time observing staff interactions with residents. The inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at 10 minute intervals the quality of interactions between staff and residents in the communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The observations took place for a total of one and half hours during the two day inspection.

Inspectors found that communication between staff and residents was very positive. Staff addressed the residents by their preferred name, used eye-contact and connected with each resident on a personal level. During the meal time staff were observed to offer a choice of meal to each resident. Residents were offered a choice of where to sit and a choice of whether to partake in activities.

The centre has CCTV cameras in use on the external doors, communal corridors and in the communal day rooms. The cameras were used in the dayrooms, where residents and their visitors would have a reasonable expectation of privacy. The cameras are monitored in the nurses’ station and the office by the person in charge and the nursing staff. There is a policy in place relating to the use of CCTV.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
Inspectors reviewed the complaints log and found that complaints had been documented, investigated and managed in line with the centre's policy. The complaints
procedure was displayed in prominent areas and described in the residents guide. There was a nominated person to deal with complaints and all complaints logged were fully investigated. Residents spoken with said that they felt that issues and complaints were listened to and dealt with in a timely manner. The satisfaction of all complainants was documented in the complaints log. Learning from complaints was identified and communicated to staff, as appropriate.

Judgment: Compliant

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors observed that staff delivered care in a respectful manner and were attentive to the residents' needs throughout the day.

On the day of inspection there was 29 residents accommodated in the centre. Of these, five residents had maximum, 13 high, four medium and seven low dependency needs. The assistant director of nursing (ADON) told the inspectors that the person in charge and the ADON were supported by two staff nurses and five carers during the day. There was one nurse and two carers rostered for the night time. The management team stated that it was not always possible to maintain the stated staffing levels due to staff illness and recruitment difficulties. Staff spoken with stated that the staffing levels on the roster did not reflect the reality of the actual staffing available to attend the needs of the residents. High levels of supervision and care were required for some residents with complex dementia related care needs. These residents had their care needs delivered within the dementia specific unit. This unit was not staffed independently but rather shared staff with the rest of the designated centre. Although this was raised as a concern by some of the care staff, Inspectors did not observe the staffing levels having a negative impact on the residents care on the day of inspection.

Unsolicited information received by the Chief Inspector identified concerns in relation to staffing levels, and staff training and development. The issues relating to training and development were substantiated on inspection. Inspectors reviewed the training records of the staff and found significant gaps in the provision of appropriate training in relation to safeguarding vulnerable adults and fire safety procedures.

On review of the training matrix, mandatory training had not been completed by some staff. Inspectors noted that four staff members had not received training in safeguarding
of vulnerable adults, and seven staff had not received fire training. Training attended by all other staff was not delivered by a suitably qualified person. The content of the fire training received did not provide the assurance that staff were aware of the procedure to be followed in the event of a fire. This issue is addressed under Outcome 7, Health and safety and risk management and an immediate compliance plan was issued to the registered provider on the day after the inspection.

Inspectors reviewed staff files and found that records to be kept in relation to staff were not in line with the requirements of Schedule 2 of the regulations. For example, from five staff files inspected, two files contained only one reference.

**Judgment:**
Non Compliant - Moderate

### Outcome 06: Safe and Suitable Premises

**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:**
The centre was laid out over two storeys with lift access to the first floor. Residents were accommodated in 22 single bedrooms and 10 double rooms. The size and layout of the bedrooms was suitable to meet the needs of the residents. All bedrooms have en-suite shower facilities. Residents have access to two external courtyards. Screening was provided in the shared bedrooms ensuring privacy during personal care. Bedrooms were seen to be individualised with personal pictures and furnishings.

The Waldron unit was identified a dementia specific unit that can accommodate four residents. The unit was small in scale and was furnished and decorated appropriately. A wooden panelled walk-way from the unit leads to a conservatory area, which was observed to be used regularly by residents. The walk-way and conservatory were not described in the centre’s Statement of Purpose and were not registered as part of the designated centre. This was a risk to residents as the area did not comply with regulatory requirements.

The premises is generally well maintained with suitable lighting, heating and ventilation. The centre is clean and suitably decorated. The centre had many antique fixtures and fittings, and furniture was dated but comfortable. The furnishings enhanced the living areas for the residents with dementia as they added to the homeliness and familiarity of the centre. There are adequate communal areas in the centre. The dayrooms were monitored by CCTV. This has been addressed under Outcome 3, Residents' rights, dignity and consultation.
The layout of the centre supports freedom of movement of residents with dementia around the personal and communal areas. Inspectors observed residents moving freely around the centre and the external gardens throughout the two days of inspection. The design of the centre offered the residents the opportunity to be involved in the ordinary domestic activities such as tending the raised beds in the garden.

There was a functioning call-bell system in place.

The directional signage in the centre required review. The design and layout of the centre could be confusing and difficult to navigate for residents with dementia. Most of the bedroom doors had no identifying features. Functional rooms for storage had the same doors as bedrooms. Residents with dementia may find it difficult to recognise their own room.

Floor coverings were inconsistent in texture and colour throughout the centre and a number of uneven floor surfaces and trip hazards were noted during inspection.

Residents have access to appropriate equipment that promoted their independence and comfort such as profile beds, wheel-chairs and comfort chairs. Inspectors found that supportive equipment was in good working order, well maintained and serviced annually.

**Judgment:**
Non Compliant - Moderate

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**Outcome 07: Health and Safety and Risk Management**

**Theme:**
Safe care and support

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
An immediate compliance plan was required in relation to the fire safety management systems within the designated centre. Actions from the last inspection in March 2019 had not been addressed.

Inspectors found that the registered provider had not taken adequate precautions against the risk of fire, such as reviewing fire precautions, arranging for the staff in the centre to be suitably trained in fire prevention and emergency procedures, including evacuation procedures, building layouts and escape routes. The person in charge did not ensure that appropriate procedures to be followed in relation to fire were displayed in a prominent place in the designated centre.
Fire safety issues found included:

- Fire training provided to all staff was inadequate and not delivered by a qualified instructor.
- Floor plan maps and way-finding maps were unclear and did not provide guidance on safe evacuation of the building.
- No fire-fighting equipment was provided in the smoking room.
- The fire policy did not reflect the fire management system used in the designated centre. For example, the existence and location of a second fire panel at reception was not described.
- A wooden walk-way and conservatory connected to the designated centre was not connected to the fire alarm system.
- Fire drills completed did not include the number of residents in a full compartment evacuation and did not provide the assurance that staff could evacuate residents safely and in a timely manner in the event of a fire, particularly at night time.
- Staff spoken with were inconsistent in their response to being asked about the procedure relating to the sounding of the fire alarm. Staff were not able to identify which fire panel to attend on the sounding of the fire alarm.
- The information on the personal emergency evacuation plans was disjointed and unclear. A summery sheet of all residents was not signed or dated and detailed only 28 out of 29 residents.

The risk management policy in the centre did not contain the information required by Regulation 26, Risk Management. The risk register contained identification of some environmental hazards. The quality of the risk assessments was inconsistent. The risks identified were not centre specific and controls to manage the generic risk were not detailed, dated or reviewed. The quality of the risk assessments was inconsistent.

**Judgment:**
Non Compliant - Major

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**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Governance and leadership arrangements for the centre required review to ensure that management systems were in place to effectively monitor the service delivered and to ensure it was safe, appropriate, consistent and met with regulatory requirements. There continues to be repeated regulatory non-compliances from the last inspection dated 7
March 2019.

Inspectors found that an area consisting of a walkway and a conservatory was regularly used by residents but had not been registered as part of the designated centre. This was a risk to residents as the area failed to meet the regulatory requirements of a designated centre. For example, the area was not connected to the fire alarm system of the designated centre.

There was a poorly defined management structure within the centre. The role and responsibilities of the person in charge and of the assistant director of nursing (person participating in management) was not clear. Inspectors observed that the lines of authority were not in line with the centre’s Statement of Purpose. The management team informed inspectors that the shortage of staff and difficulty with recruitment had an unsettling effect on the staff working within the centre. Communication with staff was poor. Some staff spoken with did not feel adequately supported by the management team.

A number of audits were made available for inspection; however, the audits did not identify trends or recommendations and were not signed or dated.

Poor compliance with Regulation 23, Governance and management is evidenced by:

- repeated non-compliances in the areas of safeguarding and safety, residents rights and dignity, suitable staffing, staff training and development, safe and suitable premises, fire safety management and governance and management.
- failure to ensure that management systems were in place to ensure that the service delivered was safe, appropriate, consistent and effectively monitored.
- failure to ensure that staff had access to suitable training.
- failure to ensure that staff files contained all the information as required in Schedule 2 of the regulations. Two files reviewed contained only one reference, one file did not contain the person’s identification, and two files did not contain a full employment history.
- failure to notify the Chief Inspector in relation to a suspected allegation of abuse.

**Judgment:**
Non-Compliant - Moderate
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Sweeney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Provider’s response to inspection report**

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<td>18/09/2019</td>
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**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: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
According to the training matrix available for review on the day of inspection four staff members had not received training in relation to safeguarding.

**1. Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
We will continue to ensure that all staff in the Centre have training for Safeguarding Vulnerable adults and when the 1 staff member who is currently out on long-term sick leave, we will ensure that he/she receives the necessary training upon return. We will also update the training matrix viewed by the inspectors which gave rise to the assurance sought.

**Proposed Timescale:** 01/12/2019

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### Outcome 03: Residents' Rights, Dignity and Consultation

**Theme:**
Person-centred care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
CCTV was used in the dayrooms, where residents and their visitors would have a reasonable expectation of privacy.

2. **Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
The Registered Provider understand that the regulation guarantees the right insofar as practical. The Registered Provider has CCTV covering all exit doors of the nursing home for security reasons. Both dayrooms have exit doors leading directly outside which are recognized common areas for valuation purposes under the Valuation Acts. There are signs in place to ensure visitors and residents are aware of CCTV in place and residents and visitors are made aware that they can visit in private in the library, the quiet room, the dining room or the residents’ bedroom. The CCTV monitor in the nurses’ station has been disabled so CCTV can only be viewed by the Person in Charge in the event of an emergency, as we consider is appropriate in the interests of the good governance of our nursing home business.

**Proposed Timescale:** 07/10/2019

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### Outcome 05: Suitable Staffing

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
On review of the training matrix, inspectors noted that four staff members had not received training in safeguarding of vulnerable adults, and seven staff had not received fire training. Training was not delivered by a suitably qualified person. The content of
the fire training received by all other staff did not provide the assurance that staff were aware of the procedure to be followed in the event of a fire.

3. **Action Required:**
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
We will continue to review this matter. Safeguarding training is an ongoing obligation and the Registered Provider continues to ensure that staff have access to appropriate training. Fire Training is carried out by an external provider twice yearly to allow all staff to have access to mandatory training. All staff have been trained up to fire warden standard so that the current Person-in-Charge can be assured that staff are aware of the procedures to follow in the event of a fire. We have a fire warden instructor on site to carry out training for any new staff.

**Proposed Timescale:** 07/10/2019

**Theme:** Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors reviewed staff files and found that records kept in relation to staff were not in line with the requirements of Schedule 2 of the regulation. For example, from five staff files inspected, two files contained only one reference.

4. **Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
A review of all staff files has been carried out and all requirements under schedule 2 are now in place.

**Proposed Timescale:** 07/10/2019

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The directional signage in the centre required review. The design and layout of the centre could be confusing and difficult to navigate for residents with dementia. Most of
the bedrooms doors had no identifying features. Floor coverings were inconsistent in texture and colour throughout the centre and a number of uneven floor surfaces and trip hazards were noted during inspection.

5. **Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
Room numbers have been reviewed and reoriented to enable easier navigation. Identifying signs are on the doors of residents who wish to have them displayed. Any resident who prefers not to have signs displayed has their wishes respected. The design of the nursing home is to make it as homely as possible.

As part of this design there are carpets throughout the corridors and for infection control reasons marmoleum is in place in the bedrooms and the dining/kitchen area and the Waldron Unit. There are tiles in all the bathrooms. The colours of the carpets are consistent on each wing and are designed as an identifying feature.

There are two graduated slopes on the upper floor which were allowed for within planning, these are included in the risk assessments and both staff and residents are aware of this and handrails are in place. No incidents of falls or trips have occurred on these gradients.

There is a lip on 2 doors, exiting the building, in built into the door frames to prevent water ingress. These are highlighted in yellow so that people are aware of them and are included in the risk register. The Registered Provider has engaged with its door specialist who will review both doors.

**Proposed Timescale:** 30/11/2019

### Outcome 07: Health and Safety and Risk Management

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
There was no fire-fighting equipment provided in the smoking room.

**6. 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:**
A fire extinguisher and a fire blanket has been put into the smoking room.
The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Staff spoken with during the inspection displayed poor knowledge on fire evacuation procedures. Staff urgently required suitable training in fire prevention and emergency procedures. The fire safety floor plan and the way-finding maps did not accurately identify the building layout and escape routes. The fire safety floor plan identified bedrooms, however, the bedrooms did not have any identifying features, such as numbers or names, in place.

7. Action Required:
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

Please state the actions you have taken or are planning to take:
Fire Warden training for each staff member has been arranged for September 25th any staff member on annual leave or sick leave will be trained up on return. Qualified fire warden instructor on staff who will complete training with them. The fire safety floor plan and way finding maps have been reviewed to make them clearer. Room numbers are currently being erected on bedroom doors to identify bedrooms.

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was no documentary evidence of simulated fire drills that included compartment evacuation, reflecting night time conditions.

8. 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:
Simulated fire drills that include compartment evacuation, reflecting night time
conditions were carried out during training. Report will be completed and submitted 26 September 19. Weekly drills will be carried out with staff to ensure improvements in times.

**Proposed Timescale:** 25/09/2019

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A conservatory and wooden walkway connected to the dementia specific unit and frequently used by residents within the grounds of the designated centre had not been registered as part of the designated centre and therefore was not connected to the fire alarm system. There are two fire panels in the centre. One main panel was located on the second floor and a second repeater panel was located on the ground floor at reception. This posed a potential risk for a delay in the response time as staff did not know which panel to attend when fire alarm sounds.

**9. Action Required:**
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

**Please state the actions you have taken or are planning to take:**
After reviewing the wooden walkway, we have made the decision to remove it. Work is to begin 26 September 2019 and will be completed by 14 October 2019. A fire risk consultant has been commissioned to carry out an assessment on the whole building on 07 October 2019. The fire action procedure has been reviewed to provide clear instructions that staff congregate at the main fire panel in the nurses station.

**Proposed Timescale:** 25/09/2019

**Theme:**
Safe care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Personal Emergency Evacuation Plans reviewed were not accurate and were not updated to reflect a change in residents evacuation needs. A summary sheet of evacuation charts was not signed or dated and did not contain the details of all the residents being accommodated in the centre.

**10. 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:
The personal emergency evacuation plans have all been updated and are now recorded on the computerized nursing documentation system so that an up-to-date summary print out can be printed at any time to reflect the current evacuation details of residents in the centre.

Proposed Timescale: 25/09/2019

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge has not displayed the correct procedures to be followed in the event of a fire in a prominent place in the designated centre.

11. Action Required:
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:
The procedures have been reviewed and placed in prominent areas around the centres.

Proposed Timescale: 25/09/2019

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was a poorly defined management structure within the centre. The role and responsibilities of the person in charge and of the assistant director of nursing (person participating in management) was not clear. Inspectors observed that the lines of authority were not in line with the centres statement of purpose.

12. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
Please note that since the Inspection the Chief Inspector accepted the application of, and registered, the current Person-in-Charge. The Statement of Purpose has been updated to reflect the registration of the Person-in-Charge.
**Proposed Timescale:** 01/01/2020

**Theme:**
Governance, Leadership and Management

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The provider failed to ensure that management systems were in place to ensure that the service delivered was safe, appropriate consistent and effectively monitored.

13. **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:**
All actions were progressed in accordance with the immediate action plan.
The current Person In Charge was appointed and registered so that there is a clear defined line of authority amongst all nurses and care staff who report to the Person In Charge.
Organisational systems are being and will be put into place, in accordance with the registration decisions of the Chief Inspector to ensure that all requisite training is identified, addressed and delivered. The Annual quality and safety review will be carried out at the end of the year to reflect the systems in place.

**Proposed Timescale:** 31/01/2020