<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Blake Manor Nursing Home</th>
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</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000390</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Cloughballymore House, Ballinderreen, Kilcolgan, Galway.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>091 796 188</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:aideen@blakemanor.ie">aideen@blakemanor.ie</a></td>
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<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Rushmore Nursing Home Limited</td>
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<tr>
<td>Lead inspector:</td>
<td>Catherine Sweeney</td>
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<tr>
<td>Support inspector(s):</td>
<td>Mary Costelloe</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 29 July 2019 09:00
To: 29 July 2019 18:00
29 July 2019 09:00
29 July 2019 18:00

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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<tr>
<td>Outcome 01: Health and Social Care Needs</td>
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<td>Substantially Compliant</td>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
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<td>Substantially Compliant</td>
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<tr>
<td>Outcome 03: Residents’ Rights, Dignity and Consultation</td>
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<td>Outcome 04: Complaints procedures</td>
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<td>Non Compliant - Moderate</td>
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<td>Outcome 05: Suitable Staffing</td>
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<td>Outcome 06: Safe and Suitable Premises</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td>Not applicable</td>
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<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 report sets out the findings of an unannounced thematic inspection. 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 October 2017. Some of the actions remain outstanding, these include the development of care plans to contain appropriate information to guide staff. The Person in Charge was not available on the day of inspection. The provider representative and two senior staff nurses facilitated the inspection.
Prior to the inspection, the person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

In total, eleven residents were suspected to have dementia but only seven had been formally diagnosed. There is no dementia care unit in the centre. Inspectors found the provider and the senior nursing staff were very committed to providing a high quality service for all residents including residents with dementia. The inspector met with residents, relatives and staff members during the inspection and tracked the journey of residents with dementia within the service. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated observation tool. The inspector also reviewed documentation such as care plans, medical records and staff rosters and training records.

Residents’ healthcare and nursing needs were met to a good standard. Residents had timely referral to healthcare services including specialist services, health and social care professionals and psycho-geriatric services. Residents had a comprehensive assessment and care plan in place that identified their health and social care needs. Care plans for residents with a diagnosis of dementia required review to ensure that interventions relating to their specific symptoms were identified and managed.

Overall, residents were safeguarded within the centre. There was a robust policy in place, and all staff had received training in the prevention of elder abuse and safeguarding. A review of the arrangements in place for the management of residents finances was required to ensure the centres compliance with the Department of Social Protection guidelines.

A review of the complaints management system was required to ensure that all complaints, concerns and minor issues are managed in line with regulation 34, Complaints procedure.

Inspectors received very positive feedback from residents and visitors in relation the staff in the centre. While inspectors observed that the number and skill mix of the staff appeared to meet the needs of the residents, assurance was required in relation to the evacuation procedure with the night time staffing complement.

The premises is generally well maintained and meets the needs of the residents. A number of issues relating to the premises were identified by inspectors on the day of inspection. These include the ventilation of some bedrooms, the lack of floor plan signage displayed, and the signage to facilitate residents with dementia. These issues ware discussed under outcome 6, Safe and suitable premises and outcome 7, Health and safety and risk management.

The arrangements in place to manage the trends from clinical audits and complaints documentation require review. A more robust system is required to ensure safe, effective monitoring of the service.
Areas of 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 Quality Standards for Residential Care Settings for Older People in Ireland.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

#### Findings:
Overall, Inspectors were satisfied that residents wellbeing and welfare was maintained to a high standard. Residents had access to appropriate medical and health and social care. Residents were enabled to make healthy living choices in the centre. Each residents assessed needs were set out in an individual care plan which was developed with the residents. Some improvements were required to ensure that care plans for residents with a diagnosis of dementia contained the information required to give effective, person-centred care.

A comprehensive assessment was completed for each resident on admission, reviewed in a timely manner in line with regulation, and as required thereafter. The assessment process included assessing the dependency level of the resident, a falls risk assessment, pressure area care risk, mobility, continence, oral health and communication needs.

Care plans were in place for each resident which detailed their individual needs and choices. Consent for treatment and care was sought and documented for each resident. Staff informed inspectors that residents right to refuse treatment was respected and documented. While residents with a diagnosis of dementia had care plans in place, the plans did not adequately document the symptoms associated with the residents dementia. The care plans did not guide staff in relation to the interventions required to address symptoms of distress and agitation in residents with a diagnosis of dementia. This issue is an outstanding action from the previous inspection.

The centre has good access to the local general practitioner (GP) service. An out-of-hours service is available from the local GP’s. Residents who wish to retain their own GP are facilitated to do so, where possible. The centre had good access to a team of allied health professionals including a dietitian, physiotherapist, occupational therapist, chiropody, tissue viability nurse, and psychiatry of later life. Residents had access to, and were facilitated to attend the services that they were entitled to under the medical card scheme and the national screening programmes.
There was evidence of residents having regular reviews by the GP, as well as regular reviews of the residents medicines. Inspectors found that residents received their medicines in a timely manner, however, some medicines management practices were not in accordance with guidance issued by Nursing and Midwifery Board of Ireland (NMBI). While there was a copy of the pharmacy order available, nursing staff had transcribed the original order. The medicine management policy required updating to reflect best practice in relation to transcribing medicines. Nursing staff signed for the administration of medicines from a chart that did not include the route of administration or the prescribers signature. This complex process posed an increased risk to residents and was not in accordance with best practice guidance.

Wounds appeared to be well managed in the centre. There was comprehensive and timely assessment of each wound. A detailed care plan including the rationale for each dressing intervention was recorded. There were no residents with pressure wounds in the centre.

The centre had a system in place to document falls. Inspectors noted that falls were well managed. All residents had a falls risk assessment complete and an associated mobility care plan that identified appropriate interventions to reduce the risk of falls. Sensor mats, crash mats and low-low beds were interventions used to manage residents falls risk.

There was a policy in place for end of life care. A comprehensive assessment of residents needs and wishes was completed for all residents nearing the end-of-life. Care plans of residents receiving palliative care were reviewed and found to be person-centred and respectful. The centre has access to palliative care home team, as appropriate.

**Judgment:**
Substantially Compliant

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
The provider and person in charge had taken measures to safeguard residents from being harmed and from suffering abuse.

There were comprehensive policies on responding to allegations of abuse. Staff spoken with and training records viewed confirmed that staff had received ongoing education in prevention of elder abuse and safeguarding. Further training was scheduled in
September 2019. The inspectors were satisfied that allegations of abuse in the past had been investigated and managed in the line with the centres policy.

Staff continued to promote a restraint-free environment, there were two bed rails in use at the time of inspection at the request of residents and the inspectors saw that alternatives such as low low beds and crash mats were in use for some residents. There were adequate assessments and care plans in place to guide staff in the use of bedrails. Regular checks on residents using bedrails were carried out and recorded. Staff had completed training on the management of restraints.

There was a positive approach to the management of behavioural, psychological symptoms and signs of dementia. Most staff had completed training in dementia care and management of responsive behaviour. Staff spoken with were knowledgeable about and could outline person-centred strategies for dealing with individual residents' responsive behaviours. A number of residents were prescribed psychotropic medicines on a 'PRN' as required basis and these were administered occasionally. Staff spoken with informed the inspector that these were always administered as a last resort only when other strategies had been trialed and possible underlying causes had been eliminated. The inspectors reviewed a sample of responsive behaviour care plans and noted that there were gaps in the detail of the interventions required for the management of these behaviours. This issue is addressed under Outcome 1 Health and social care.

There was evidence of regular review by the General Practitioner (GP) as well as regular reviews of medications. There was access and referral to psychiatry services and Antecedent-Behavior-Consequence (ABC) charts were used to record episodes of behaviours in line with the centres policy.

The provider acted as pension agent for one resident. Additional safeguards were required to ensure that pensions collected from the Department of Social Welfare were paid into an interest bearing account on behalf of residents, in line with Department of Social Protection guidelines. The provider held small amounts of cash for residents on site, and this was stored securely, with double signing and an accurate log of incoming and outgoing balance providing safeguards for people's valuables. Receipts were available for all purchases. The accounts were regularly audited by senior management. Residents had access to money being managed by the provider at all times. All residents had access to a secure lockable locker in their bedrooms should they wish to securely store any personal items.

The inspectors reviewed a sample of staff files and noted that safeguarding measures such as Garda vetting were in place. The person in charge confirmed that Garda vetting was in place for all staff and persons who provided services in the centre.

The inspector observed staff interacting with residents in a respectful and friendly manner. Residents were observed to be relaxed and happy in the company of staff. Some residents spoken with stated that they felt safe and secure living in the centre.

Judgment:
Substantially Compliant
Outcome 03: Residents’ Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
The inspectors were satisfied that residents were consulted in the organisation of the centre, and that their privacy and dignity was respected.

Residents committee meetings continued to be held on a regular basis and were facilitated by the activities coordinator. Notice of upcoming meetings were displayed and relatives were invited to attend. Minutes of meetings were recorded and displayed on the notice board. Issues discussed at recent meetings included planned day trips, feedback from residents regarding in-house activities and recent shopping trips as well as upcoming events and activities. The annual residents and families satisfaction survey had been completed, the results which indicated satisfaction with the care and service provided. The inspectors observed that the management team and staff consulted with residents including residents with dementia throughout the day of inspection.

The inspectors noted that the privacy and dignity of residents was well respected. All residents had single or twin bedrooms with en suite facilities. Bedroom and bathroom doors were closed when personal care was being delivered. Staff were observed to knock and wait before entering bedrooms. Adequate screening curtains were provided in shared bedrooms.

Residents were treated with respect. The inspectors heard staff addressing residents by their preferred names and speaking in a clear, respectful and courteous manner. Staff paid particular attention to residents’ appearance, dress and personal hygiene and were observed to be caring towards the residents. Residents choose what they liked to wear. The hairdresser visited weekly and some residents availed of the service.

Residents’ religious and political rights were facilitated. The local priest visited and said Mass once a month. A minister of the Eucharist visited and offered holy communion to residents each week. Residents were supported to recite the daily rosary. A prayer room was located on the lower ground floor and residents could spend quiet reflective time there if they wished. An outdoor mass had been held in May 2019 in the grounds of the nursing home and many members of the local community had attended. The person in charge told inspectors that residents of varying religious beliefs were facilitated as required. She also told inspectors that residents were facilitated to vote and explained that residents had been facilitated to vote in-house during the recent elections.

There was an open visiting policy in place. The inspectors observed many visitors coming and going during the day of inspection. There was a variety of spaces that
Residents could meet with visitors in private if they wished.

Residents had access to information and news, daily and weekly local newspapers, the local parish newsletter, notice boards, radio, television and Wi-Fi were available. Residents spoken with told inspectors that daily newspapers were delivered each morning. Some residents spoke of enjoying reading the newspapers and also enjoying reading books which were available from the library which visited every two weeks.

Residents had access to advocacy services and the contact details for the local SAGE (support and advocacy service for older people) advocate were displayed.

As part of the inspection, the inspectors spent a period 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 five 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 half hour on each of the inspection days. An overview of the observations is provided below:

The inspectors found that for 100% of the observation period (total observation period of 60 minutes) the quality of interaction score was +2 (positive connective care). Staff knew the residents well, they connected with each resident on a personal level. Staff made eye contact and greeted residents individually by their preferred names, staff offered choice such as choice of preferred drinks and snacks, preferred place to sit, choice of having a clothing protector, staff supported a resident who was anxious and wished to go for a walk. Staff sat beside residents and were observed offering assistance in a respectful and dignified manner to residents who required assistance with eating.

Judgment:
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:**
The centre had a policy and procedures in place for the management of complaints. The policy was accessible to all residents within the residents guide, a copy of which was in place in each resident's room. The policy was also displayed in a prominent place in the reception area of the centre. The complaints process, nominated person to deal with all
complaints and appeals process is clearly identified within the policy. However, inspectors found that complaints were not documented, investigated or responded to in line with the centres policy. No formal complaints had been recorded since the last inspection in Oct 2017.
A diary was in place to record 'minor issues, concerns, comments'. The diary relating to 2018 had no issues recorded. The current diary for 2019 had two recorded entries relating to missing toiletry items. The investigations, responses and outcomes were not identified. The satisfaction of the complainant was not documented. There was no process in place to implement learning from complaints received. A full review of the documentation of complaints was required.

**Judgment:**
Non Compliant - Moderate

### Outcome 05: Suitable Staffing

**Theme:**
Workforce

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

**Findings:**
On the day of inspection there were 31 residents living in the centre. There were six residents assessed with maximum dependency level, seven high dependency, 13 medium and five residents of low dependency level. One resident was in hospital at the time of inspection.

Staff members demonstrated a good knowledge of the residents and were familiar with their individual needs. Residents told inspectors that they had very positive relationships with staff. They told inspectors that staff were kind and respectful to them at all times. This was observed by inspectors on the day of inspection.

Overall, the inspectors found the staffing numbers and skill mix in the centre was appropriate to meet the needs of the residents, and to the design and layout of the building. However, assurance was required in relation to fire evacuation procedures with the night time staffing levels provided.

A planned and actual staff roster was reviewed and matched the staff on duty on the day of inspection. There was a nurse on duty at all times. However, the roster did not identify the nurse-in-charge or the deputising arrangements in place in the absence of the person-in-charge.

All staff had up-to-date mandatory training and had completed other education and training needs to meet the needs of the residents. There was adequate supervision in place for all staff members. Staff spoken with confirmed that they had sufficient time to
carry out their duties and responsibilities. A review of the staffing files found that recruitment and induction processes were in line with regulation and best practice. There was evidence that Garda Síochána Vetting had been obtained for all staff. There were no volunteers working in the centre.

A review of nighttime staffing numbers is required to provide assurances that the residents can be evacuated safely in the event of an emergency. This issue is actioned under Outcome 7, Health and safety and risk management.

**Judgment:**
Substantially Compliant

### Outcome 06: Safe and Suitable Premises

**Theme:**
Effective care and support

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

**Findings:**
The centre is a historic three-storey building which was refurbished by the provider in 2008. The living and accommodation areas were provided over three floors. Each floor was accessible by a number of stairs, a battery operated chair-lift and an accessible lift. The centre comprised of 27 single bedrooms and six twin bedrooms. The twin rooms were large and allowed for free movements of residents and staff, hoists and other assistive equipment. Adequate dividing curtains were provided in shared bedrooms to ensure privacy for personal care. The first floor accommodated 18 residents, the ground floor 15 residents and the lower ground floor six residents. The size and layout of the bedrooms was suitable to meet the needs of the residents.

The design and layout of the centre was suitable and appropriate for the needs of the residents living in the centre. The centre was homely and comfortable. Both residents and relatives told inspectors that there was a variety of communal spaces where they enjoyed spending their day. Residents with dementia had ample access to quiet indoor space. The furniture, fixtures and fittings were attractive and appropriate for the design of the centre. The centre was clean and well maintained. There was suitable storage in all bedrooms for residents possessions. The centre had a large laundry facility and a large kitchen with a lift to transport food which serviced the dining room.

The centre was warm on the day of inspection. The temperature of the dayroom was monitored to ensure that the temperature was maintained at appropriate levels.

Inspectors noted that there was insufficient ventilation in parts of the building. There was no natural ventilation in some bedrooms as the windows could not be opened. The manager advised that a glazed panel had been provided to the interior side of the these
windows to prevent draughts during the winter months as the windows were part of the protected building structure and could not be replaced. During the inspection, the manager arranged for the glazed panels to be removed which then allowed the windows to be opened. The mechanical extract ventilation system provided to many internally located bathrooms and en suites were not in working order.

The signage in the centre requires review as the layout of the centre did not support the freedom of movement for residents with dementia to common areas and to their personal spaces.

Some bedrooms were found to be decorated in a person-centred way with family photographs, residents art work and personal items. Other rooms were bare and not decorated to reflect the individual resident's personal space. Bedrooms were not individually identified to assist residents with dementia to recognise their room.

There was an accessible outdoor area on the ground floor that included a smoking area, raised flower beds and patio furniture. A second outdoor patio was accessible using a key code from the main day room on the ground floor. Residents reported using the outdoor areas frequently. The garden areas could be enjoyed from inside and outside. A small prayer room was located on the lower ground floor. Grab rails were used throughout the centre to support independent walking.

**Judgment:**
Substantially Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
Some risks were identified during the course of the inspection which required immediate attention.

Inspectors had concerns that risks in relation to unrestricted window openings on the ground and first floors at the rear of the building had not been identified by the management team. There were a number of windows in some residents' bedrooms and others located in communal areas of the centre which could be opened wide without restriction which posed a risk to residents. Inspectors informed the manager of the risks identified and requested that they be addressed as a matter of urgency. The manager undertook to carry out a risk assessment of all windows and to have window restrictors fitted. Inspectors observed that these restrictors had been fitted before the end of the inspection.
There were policies and procedures in place in relation to fire safety. The servicing of the fire alarm system and fire equipment was up-to-date. There was evidence of regular fire safety checks being carried out, all staff had received on-going fire safety training and regular fire drills including evacuation being carried out. However, fire drill records required improvement in order to provide assurances that residents could be evacuated safely in a timely manner in the event of fire particularly at night time. Records reviewed showed that while fire drills were being carried out, there were no records to indicate the time taken to evacuate individual fire compartments simulating night time staffing levels. Bedrooms were located on three floors, compartments varied in size and could accommodate three to six residents. In addition, some residents were assessed as requiring the assistance of two staff members. There were three staff rostered in the centre between 10pm and 7am. The fire drills documented did not provide assurance that safe evacuation of residents in the event of an emergency during these hours could take place. 

Other risks were identified by inspectors during the course of the inspection which were not included in the centre’s risk register such as

- There was no fire extinguisher available in or near the outdoor designated smoking area.
- A broken glass picture frame was left unattended in a residents bedroom which posed a risk of injury.
- The procedure in relation to the use of the chair lift was not available to staff, staff spoken with were not familiar with how to operate same. The battery operated chair-lift was part of the emergency plan for use in the event of loss of power or the evacuation of immobile residents from the top floor in an emergency situation.
- Guidance for actions in the event of fire were unclear, for example, floor plans identifying escape routes were not displayed in the centre and the guidance provided in the health and safety policy and fire safety policy was contradictory. This could cause confusion in the event of an emergency and poses a risk to residents, visitors and staff.

Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors noted that some improvements were required to governance systems to ensure that there was effective oversight of risk management, including the
identification and assessment of risks, fire safety evacuation and complaints management.

The management team indicated a positive attitude to the areas identified for improvement on the day of inspection, issues requiring urgent attention were addressed and a verbal commitment was given that other areas requiring improvement would be addressed in a timely manner. A robust compliance plan response is required to address these deficits.

There was a clearly defined management structure within the centre. The person in charge (PIC) was supported by two senior nurses. The registered provider representative participated in the management of the centre, supporting the PIC with governance and administration. Improvements were required to ensure the management systems were effective. While there were systems in place to review the quality and safety of care, the key trends and recommendations from these systems were not identified and incorporated in a quality improvement plan.

For example, a variety of clinical audits were completed in the centre. There were no documented actions based on the audit findings in place. This issue was also evident in the documentation of complaints described under Outcome 4: Complaints and the risk management within the centre described under Outcome 7: Health and safety and risk management.

The centre was adequately insured against accidents or injury to residents.

**Judgment:**
Non Compliant - Moderate

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**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
Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider’s response to inspection report

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<th>Blake Manor Nursing Home</th>
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<td>OSV-0000390</td>
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<tr>
<td>Date of inspection:</td>
<td>29/07/2019</td>
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<tr>
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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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The care plans of residents with symptoms of dementia did not contain the detail required to guide care.

1. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
that resident’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
Care plans for residents with dementia are currently being reviewed to ensure they contain the information required to guide care.

**Proposed Timescale:** 30/09/2019

**Theme:**
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Assurance is required to ensure that the transcribing system within the centre is in line with professional guidelines.

2. **Action Required:**
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident’s pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
Meeting held with pharmacy – Medication Administration Record will include Route of Administration.
Orders will no longer be transcribed.

**Proposed Timescale:** 16/09/2019

**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:
Additional safeguards were required to ensure that pensions collected from the Department of Social Welfare were paid into an interest bearing account on behalf of residents in line with Department of Social Protection guidelines.

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

Please state the actions you have taken or are planning to take:
Several attempts have been made by the provider to open an interest bearing account for 1 resident. Due to historic circumstances this remains an ongoing issue. Provider has
been working with the bank in an attempt to resolve this. Staff from the bank have visited the Nursing Home and documentation has been supplied to them as requested. Provider has also contacted the local councillor who has agreed to assist with this issue. Provider is awaiting feedback from both parties.

**Proposed Timescale:** 03/09/2019

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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
No record of complaints, investigations, responses and outcomes were kept in the centre.

4. **Action Required:**
Under Regulation 34(2) you are required to: Fully and properly record all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are and ensure such records are in addition to and distinct from a resident’s individual care plan.

Please state the actions you have taken or are planning to take:
A revised complaints log has been initiated and staff have been made aware of the changes and the requirement to record all complaints, including minor issues, and actions taken.
The complaints policy has been updated to reflect and guide practice.

**Proposed Timescale:** 30/07/2019

| Theme: Person-centred care and support |

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider does not have a process in place to implement learning from complaints.

5. **Action Required:**
Under Regulation 34(1)(h) you are required to: Put in place any measures required for improvement in response to a complaint.

Please state the actions you have taken or are planning to take:
A monthly review of complaints now takes place by the Person in Charge. Learning outcomes and any improvements implemented as a result of complaints are now being documented.
The complaints policy has been updated to reflect the change and guide practice.
**Proposed Timescale:** 30/07/2019

### Outcome 05: Suitable Staffing

**Theme:** Workforce

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The nurse-in-charge is not identified as such on the daily roster.

6. **Action Required:**
Under Regulation 21(5) you are required to: Retain the records set out in paragraphs (7) and (8) of Schedule 4 for a period of not less than 7 years from the date of their making.

**Please state the actions you have taken or are planning to take:**
The Nurse in Charge is now identified on the daily roster.

**Proposed Timescale:** 31/07/2019

### 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:**
There was insufficient ventilation to parts of the building. There was no natural ventilation in some bedrooms as the windows could not be opened. The mechanical extract ventilation system provided to many internally located bathrooms and en suites were not in working order. Also, The signage in the centre requires review as the layout of the centre does not support the freedom of movement for residents with dementia to common areas and to their personal spaces.

7. **Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
Natural ventilation was restored on the day of inspection with the removal of the secondary glazing and this will remain off until our mechanical ventilation issue has been resolved.

We are working with a local signage company to change/design signage in our home to
support freedom of movement for clients with dementia to common areas and to their personal spaces.

**Proposed Timescale:** 31/10/2019

### 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:

Risks had not been identified and assessed throughout the centre. For example, some windows on the ground and first floors could be opened wide without restriction, floor plans identifying escape routes were not displayed, broken glass had been left unattended in a residents bedroom, the procedure in relation to the use of the chair lift was not available to staff, staff spoken with were not familiar with how to operate same and guidance for actions in the event of fire were unclear, the guidance provided in the health and safety policy and fire safety policy was contradictory.

### 8. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

- All windows now have restrictors fitted.
- Floor plans displayed.
- Staff who are unfamiliar with the use of the chair lift are being trained in same.
- Procedure is displayed at location.
- Use of chair lift had been added to the induction process for new employees.
- Fire policy and health & safety policy have been reviewed to correlate procedures.

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

**Theme:** Safe care and support

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

Fire drill records required improvement in order to provide assurances that residents could be evacuated safely in a timely manner in the event of fire particularly at night time. Fire plans indicating means of escape were not displayed in the centre. Staff did not know how to use the chair-lift.
9. **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:**
Floor plans displayed. Fire Action notices have always been displayed throughout the Nursing Home.
Staff who are unfamiliar with the use of use of the chair lift are being trained in same.
Fire Drill Records have been reviewed to provide clearer information.
Fire Drills are conducted using night time staffing levels to ensure compartmental evacuation procedures are safe and effective.

**Proposed Timescale:** 06/09/2019

**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 extinguisher provided in the outdoor smoking area.

10. **Action Required:**
Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

**Please state the actions you have taken or are planning to take:**
Fire Extinguisher to be provided in outdoor smoking area.

**Proposed Timescale:** 03/09/2019

**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:
Key trends and recommendations from the centres' governance systems were not identified and incorporated in a quality improvement plan. Inspectors noted that some improvements were required to governance systems to ensure that there was effective oversight of risk management, including the identification and assessment of risk, fire safety and complaints management.

11. **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
Please state the actions you have taken or are planning to take:
Complaints System Reviewed.
Fire Safety Drill Records reviewed.
**Safety Statement and Risk Management system is currently under review.**
Monthly management meetings to be held to monitor the effectiveness of systems and audits. Minutes of same to be recorded.
The results of these will be included to inform the annual quality improvement plan.

**Proposed Timescale:** 31/10/2019