<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Beechlawn House Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>ORG-0000115</td>
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<tr>
<td>Centre address:</td>
<td>Beechlawn House Campus, High Park, Gracepark Road, Drumcondra, Dublin 9.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 836 9622</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:catherine.condon@olc.ie">catherine.condon@olc.ie</a></td>
</tr>
<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>Sisters of Our Lady of Charity</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Catherine Condon</td>
</tr>
<tr>
<td>Person in charge:</td>
<td>Natasha Kennedy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
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<tr>
<td>Support inspector(s):</td>
<td>None</td>
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<tr>
<td>Type of inspection:</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>39</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.

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

The inspection took place over the following dates and times
From: To:
12 June 2014 09:00 12 June 2014 17:30

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

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<td>Outcome 03: Suitable Person in Charge</td>
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<td>Outcome 06: Safeguarding and Safety</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Medication Management</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10: Reviewing and improving the quality and safety of care</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<td>Outcome 15: Food and Nutrition</td>
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<td>Outcome 16: Residents Rights, Dignity and Consultation</td>
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<td>Outcome 17: Residents clothing and personal property and possessions</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This monitoring inspection was announced following an application by the provider to renew the registration of the centre. As part of the monitoring inspection, the inspector met with residents and staff members. The inspector observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files. Prior to the inspection, the inspector reviewed written evidence from a suitably qualified person confirming the building meets all the statutory requirements of the fire and planning authorities in relation to the use of the building as residential centre for older people. All documents submitted by the nominated person on behalf of the provider, for the purposes of application to register were found to be satisfactory.
The inspectors confirmed that the nominated person on behalf of the provider had fully addressed five of the six outcomes from the last monitoring inspection which took place on 21 June 2013. The outstanding action related to the premises.

Overall, the inspector found the nominated person on behalf of the provider and the person in charge, had undertaken some preparation for inspection. The provider and the person in charge were found to be operating in compliance with the conditions of registration but not in substantial compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. The centre was in compliance with ten of the eighteen outcomes inspected against. Eight outcomes were not fully met.

The inspector found that the governance structure was no longer robust as the person in charge was leaving her post and a new person in charge had not been appointed to date. There was no succession management plan and the roles and responsibilities of those in management posts were not clearly defined.

Staff turnover was high and this was having an negative impact on residents. Alleged staff misconduct was not being notified to the Authority as required.

Documents such as the statement of purpose, contracts of care, medication prescription, administration charts, lists of residents’ personal possessions and schedule two documents for all staff had been revised since the last inspection and were now in compliance with legislation.

The policy for complaints management was not been followed and it was not clear if complaints were been overseen by an independent person. Resident assessments were not detailed and identified needs did not have a corresponding care plan in place. End of life care was not to a high standard, staff required further training. The service of food and provision of assistive utensils was required.

Reviews of the quality of life for residents and quality of care completed to date had not been reported back to residents and did not involve resident representatives.

The 10 bedded room required re-development in order to meet legislative requirements and alternative equipment to restrictive devices needed to be provided.

The action plans at the end of this report reflect these non-compliances.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

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

Findings:
There was a written statement of purpose that accurately described the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care was provided, reflected the diverse needs of residents. It contained all of the information required by Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. It was reviewed in May 2014 and staff were familiar with its content.

Judgement:
Compliant

Outcome 02: Contract for the Provision of Services
Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Leadership, Governance and Management

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

Findings:
A contract of care was available for each resident living in the centre. A sample of three were reviewed, each resident had agreed the written contract within a month of admission. Each contract included details of the services to be provided for the resident and they now included the fees to be charged, inclusive of any possible additional charges.
Judgement:
Compliant

**Outcome 03: Suitable Person in Charge**
The designated centre is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

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

**Findings:**
While this outcome was complaint with the regulations in that there was a person in charge of the centre, the inspector was concerned regarding the ongoing governance and level of compliance in the centre as evidence under outcomes 10, 11, 12, 13 and 14 which are discussed in more detail later in the report. The inspector was further concerned to learn that the person in charge had resigned from her post and was due to leave and while interim arrangements were in place significant work was required to bring the centre into compliance.

There was a governance structure in place, however, the inspector was not satisfied that it was robust. Lines of authority and accountability among the management team were not clear. For example, the catering manager did not have the authority to order necessary equipment and therefore, beakers were not available for residents' use and the person in charge was not carrying out her role as complaints officer both of which are discussed in more detail under outcome 13.

Judgement:
Compliant

**Outcome 04: Records and documentation to be kept at a designated centre**
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended).

**Theme:**
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection:
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The records listed in Part 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) were maintained in a manner that ensured completeness, accuracy and ease of retrieval. The designated centre was adequately insured against accidents or injury to residents, staff and visitors.

The designated centre had all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). However, records were not always kept in a safe and secure place. The inspector observed resident files unsecured on a desk within an open office.

A sample of two staff files were reviewed. They now contained all the documents outlined in Schedule 2.

Judgement:
Non Compliant - Moderate

Outcome 05: Absence of the person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:
Leadership, Governance and Management

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

Findings:
The Authority was notified of the resignation of the person in charge as required by the regulations. As mentioned under outcome 3, the inspector was not satisfied with the arrangements that had been put in place for her absence. The person nominated to deputise in for the person in charge on the current registration certificate was the nominated person on behalf of the provider, also a nurse. However, she had pre-arranged leave the week following this inspection, leaving the newly appointed clinical nurse manager in charge of the centre for four days without adequate support structures in place. The nominated person on behalf of the provider was asked to put support structures in place for the newly appointed clinical nurse manager for the four days and submit it for review to the inspector within 24 hours. This was received, reviewed and the inspector was satisfied that adequate support structures were put in place for the four days.
Judgement:
Compliant

**Outcome 06: Safeguarding and Safety**
*Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse.*

**Theme:**
Safe Care and Support

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

**Findings:**
The inspector saw that there was a policy in place on the prevention, detection and response to elder abuse and found that it gave guidance to staff on the types of abuse, the procedures for reporting alleged abuse and the procedures to follow investigating an allegation of elder abuse. The Authority had been notified of one incident of alleged abuse since the last inspection. The inspector was satisfied that this had been investigated as per the centres policy. Staff spoken to on the day of inspection were aware of the different types of elder abuse and their responsibilities in reporting suspected elder abuse. Records reviewed confirmed this training had been provided to staff on number of dates since the last inspection. Garda Síochána vetting was in place for staff employed by the provider. This was evidenced by a review of a sample of two staff files.

Residents spoken to confirmed that they felt safe in the centre. There was secure gate at the entry into the grounds. There was a member of staff on the reception desk from 8am to 4pm Monday to Friday and a security guard after 4pm. All visitors to the centre were requested to sign in.

Judgement:
Compliant

**Outcome 07: Health and Safety and Risk Management**
The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe Care and Support

**Outstanding requirement(s) from previous inspection:**
No actions were required from the previous inspection.
Findings:
There was a risk management policy in place, it met the legislative requirements. It outlined how to undertake a risk assessment and identified that a health and safety committee was in place. The health and safety policy and safety statement was in place - it had been updated by qualified personnel and was signed and dated by the nominated person on behalf of the provider. The health and safety representative confirmed that the committee met on a quarterly basis and minutes of their meetings were available for review. A risk assessment was completed on an annual basis and was updated when any new risk was identified. However, it required more specific details of the actions put in place to control risks identified. A culture of managing any identified risk was evident, in most areas. However the inspector was concerned that the practice of giving out hot cups/mugs of drinks with no side-table facility for resident did not promote safety and increased the risk of injury to residents. This is discussed in more detail in outcome 15.

An emergency plan was in place to outline clear procedures to follow in the event of loss of electric power, flood, gas leak or security concerns. The inspector spoke to staff and found they were familiar with the contents of the emergency plan, reporting structures in case of an emergency and nearby buildings where residents could be evacuated to. Hand-washing and drying facilities and hand disinfectant gels were available throughout the centre.

The fire alarm, emergency lighting and fire fighting equipment were maintained, and all staff had attended fire safety and evacuation training. Means of escape were clear and unobstructed. Records reviewed showed that staff practised regular fire drills.

Judgement:
Non Compliant - Minor

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**Outcome 08: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe Care and Support

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

**Findings:**
The inspector found that each resident was protected by the designated centre’s policies and procedures for medication management. The inspector noted that times on the medication prescription chart and medication administration chart had been revised. Times identified on both charts now corresponded with each other. Resident who were receiving crushed medications now had them individually prescribed to be administered as crushed.
The person in charge was completing medication management audits on a continuous consistent basis, which had given rise to improved medication management practices.

Judgement:
Compliant

Outcomes and Findings:

**Outcome 09: Notification of Incidents**

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

**Theme:**
Safe Care and Support

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

**Findings:**
The person in charge was aware of her responsibility to maintain a record of all incidents occurring in the centre. She was aware of her responsibility of notifying the Chief Inspector of notifiable incidents within three days. The inspector followed-up on notifications received since the last inspection. The person in charge had informed the Chief Inspector at the end of each quarter the occurrence of any accidents. The inspector saw evidence that a number of allegations of staff misconduct had been reported directly to the nominated person on behalf of the provider who investigated each individual incident. However, the chief inspector had not been notified of these allegations of staff misconduct.

Judgement:
Non Compliant - Moderate

**Outcome 10: Reviewing and improving the quality and safety of care**
The quality of care and experience of the residents are monitored and developed on an ongoing basis.

**Theme:**
Effective Care and Support

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

**Findings:**
There was a system in place to review and monitor the quality and safety of care and the quality of life of residents. However, it did not cover all aspects of care. For example, the use of restraint within the centre was not audited. Other areas of practice which had reportedly been audited were not reviewed in sufficient detail to inform
improvements. For example, a recent audit of nursing documentation included a review of just one residents nursing documents, when there were 39 residents in the centre.

While residents' were consulted with at their monthly residents meetings about their care and services provided to them. There was no evidence that a report in respect of the reviews conducted to date had been developed or a copy of the report made available to residents. There was no evidence that they or their representatives were involved in feedback in relation to audits completed to date.

**Judgement:**
Non Compliant - Moderate

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**Outcome 11: Health and Social Care Needs**

Each residents wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each residents assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.

**Theme:**
Effective Care and Support

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

**Findings:**
The care and welfare of all residents was found to be adequate with appropriate healthcare provision and access to all allied health care professionals. Arrangements for general practitioner (GP) services and access to on call cover for out-of-hours GP services were in place. Residents confirmed that their GP visited regularly. A review of a number of resident files showed that residents’ were seen by their GP within a six month period and had their medications reviewed. This review also confirmed regular input from psychiatry of old age, palliative care team, physiotherapist and other health care professionals without delay. The centre had a policy in place for the admission, temporary absence and discharge of residents. Pre-admission assessments had been completed. The admission policy included details of information required before any decision to admit a resident had been made by the person in charge. The inspector was satisfied that the governance of admissions and discharges was to a high standard. Records of transfer and discharge letters to and from the centre were available in resident files.

Resident assessments were completed. However, care plans were not always in place for each identified need. Some care plans contained contradictory information to the assessment. For example, one residents' assessment stated that the resident was on a high calorie, high protein diet, her care plan stated she was on both an normal diet and
a high calorie, high protein diet. Another resident was assessed as being at low risk of falling. However, the restraint assessment form completed stated that two bedrails were been used because the resident could attempt to get out of bed. The staff nurse told the inspector that the resident in question could not move. The restraint assessment form completed for this resident and two other residents who had restraints in use, did not identify alternatives that had been tried, tested and failed prior to a form of restraint been used.

There was evidence that some residents were involved in their care plan development.

Judgement:
Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises
The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Care and Support

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

Findings:
The design and layout was adequate to meet the assessed needs of the residents. However, the high dependency unit which contained ten beds (5 on each side of the unit) and one wash hand basin was not adequate to meet the National Quality Standards for Residential Care Settings for Older People in Ireland. It provided a minimum amount of personal space for each resident and although privacy screens were in place, the layout of the room impinged on the privacy of residents. The inspector was informed by the nominated person on behalf of the provider that plans had been drawn up but planning permission had not yet been obtained to develop this ten bedded room and extend the centre.

The building was save and secure. It was situated in grounds behind a secure gate. The centre was purpose-built, with a good standard of private and communal space and facilities. The environment was observed to be bright and very clean throughout, with appropriate pictures, furnishings and colour schemes. All areas were warm, clean and well maintained.

Two visitor’s toilets are located on the ground floor. Adequate numbers of assisted showers, baths and toilet facilities were available. Sufficient communal dining and sitting areas were available for the number of residents accommodated. Spacious, secure and well-maintained grounds with plenty of seating was available for residents’ and visitors
to enjoy.

There was some assistive equipment available to meet the needs of the residents, such as electric beds, hoists, pressure relieving mattresses, wheelchairs and rolator walking frames. However, staff informed the inspector that there was minimum equipment available to use as an alternative to using restraints. For example, there was one low, low bed available in the centre. In addition there was insufficient assistive tableware such as beakers for use by residents. This is discussed in more detail under outcome 15. The provider informed the inspector that the purchasing of some equipment was included in the 2014 budget but had not been ordered or purchased to date.

The wide corridors enable easy access for residents in wheelchairs and those people using frames or other mobility appliances. The inspector observed residents moving independently around the corridors, using their individual mobility aids. Hoists and other equipment were all maintained and service records were up-to-date.

An emphasis on the promotion of cleanliness and prevention of infection was evidenced by up to date and signed cleaning schedules and practices.

Judgement:
Non Compliant - Major

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

Theme:
Person-centred care and support

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

Findings:
The inspector saw there was a complaints policy in place and the complaints procedure was on display throughout the centre. The person in charge was the complaint’s officer named within the policy. However, records reviewed showed that the management of complaints was inconsistent and not in line with the policy. The person in charge was the complaints person for complaints made by residents only. The nominated person on behalf of the provider or a person nominated (usually an investigator from within the management team) was investigating complaints made by staff. This excluded the person in charge, the named complaints officer in the complaints policy.

Residents told the inspector that they would speak to the person in charge or any of the staff with any issue/complaint they may have. Resident and relative questionnaires confirmed that they were satisfied that the arrangements in place to deal with complaints.
Inspectors found that all written and verbal complaints had been dealt with or investigated. A review of the complaints file showed records of the actions taken to investigate and resolve complaints, the outcome of the complaint and the complainants’ level of satisfaction with the outcome was also recorded.

It was not clear who was overseeing complaints.

**Judgement:**
Non Compliant - Moderate

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

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

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

**Findings:**
There was an end of life policy in place. However, records reviewed showed it had not been implemented. There was resident receiving end of life care on the day of inspection. The resident was residing in a five bedded room as there was no vacant single bedroom. The inspector saw there was a small sitting room which relatives had access to. The resident appeared comfortable and was receiving an adequate standard of nursing care.

The inspector saw that the resident did have an end of life care plan in place but it did not include details of all the care required by the dying resident. For example, the resident was receiving two different forms of pain relief but pain assessments were not mentioned in the care plan and were not being recorded by staff.

The records reviewed showed that the residents general practitioner, next of kin and nursing staff had discussed the residents plan for end of life care. However, there was no record to reflect the residents personal end of life wishes/ preferences as these had not been recorded prior to the residents condition deteriorating. The residents’ spiritual needs were been met from within the centre.

Some staff had attended education in relation to spiritual care at the end of life and others had attended a syringe driver workshop. However, the inspector found that all care staff required further education about end of life care to ensure they could meet the needs of the dying resident.

**Judgement:**
Non Compliant - Moderate
### Outcome 15: Food and Nutrition

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

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

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

**Findings:**
The inspector observed morning tea service and lunch time service in one of the two dining rooms. The food was properly prepared and cooked and appeared wholesome and nutritious. However, the service required improvement and the actions for these improvements are referenced under outcomes 7 and 12.

The dining room was appropriately furnished and welcoming. Table settings were pleasant and included condiments, napkins and appropriate place settings for all residents. A choice of cold drinks were available with their meal. Morning tea service offered a variety of drinks including soup, fresh cakes and scones. However, the service was not good. As outlined under outcome 7 residents had no side tables to rest their hot drinks on and were seen trying to balance them on the arms of chairs which posed a significant risk of injury. In addition the inspector noted that cakes were served on napkins and not side plates and cups were handed to residents with no saucers. The inspector was informed that there were no beakers available for residents.'

Overall, residents told the inspector they enjoyed the food and the choices available to them. A detailed menu was displayed outside the dining room identifying the menu choices for the day in large font. The same menu choice was available for residents on a modified consistency diet. Catering staff had a good knowledge of each residents needs and this was displayed discreetly in the kitchen. Staff assisted in ensuring residents obtained their preferred food choices. Staff spoke to residents and were knowledgeable about their likes and dislikes and offered residents choice. The inspector was satisfied the mealtime experience was enjoyed by residents who took their meals in the dining room and to those who ate their meal in their bedroom. Appropriate assistance was offered to residents who required assistance in both their own room and in the dining rooms.

**Judgement:**
Compliant

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### Outcome 16: Residents Rights, Dignity and Consultation

*Residents are consulted with and participate in the organisation of the centre. Each residents privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence.*
Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Residents told the inspector that they enjoyed a variety of activities. They had a choice to participate in group or one-to-one activities. The inspector saw a group of residents participating in an exercise class. A seven day programme was in place with one full-time activities co-ordinator employed and one staff member on a part time basis.

Residents confirmed that they were treated with respect and dignity and said that they felt valued. They described staff as interested in their wellbeing and keen to assist them. The person in charge knew the residents well and they knew her. During the day, residents were able to move around the centre freely and visitors were welcomed throughout the day at times that suited residents. The reception area was welcoming with a comfortable seating private visitor’s room was readily available for any meetings or quieter moments.

The residents were facilitated to vote at the recent election and are kept up to date with current affairs. Newspapers are delivered daily, and magazines and books were available. Notices and information to inform residents was displayed in large print.

Judgement:
Compliant

Outcome 17: Residents clothing and personal property and possessions
Adequate space is provided for residents personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Findings:
The policy in relation to residents’ personal property and possessions had been updated and it reflected the legislative requirements and practices to be followed in the centre. The practice of managing residents’ petty cash was found to be robust on the last inspection and therefore was not reviewed on this inspection. A list of personal possessions signed by the resident and/or staff member was now present in residents’ files. A sample of three were reviewed.
Judgement:
Compliant

**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

**Theme:**
Workforce

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

**Findings:**
There were appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. A review of the actual staff roster confirmed that there were two staff nurses and six care attendants on duty from 8am to 8pm together with the person in charge and newly appointed clinical nurse manager from 8am to 4pm and one staff nurse and three carers from 8pm to 8am. Staff had up-to-date mandatory training in place and access to education and training to meet the needs of residents.

Staff spoken with confirmed they had the required mandatory training in place and records reviewed confirmed this. Records provided showed staff had completed additional training in a variety of clinical topics including Cardio Pulmonary Resuscitation and first aid, dementia and associated behaviours that may challenge, person-centred care planning, medication management, health and safety at work and infection control. There were no volunteers working in the centre.

The staff recruitment policy reflected the legislative requirements. As mentioned under outcome 4, staff files reviewed confirmed that all the required documents outlined in Schedule 2 of the Regulations were now in place.

On review of the centres application to register the inspector noted there was a high percentage of staff turnover. Since the last inspection on 21 June 2013, there had been a turnover of 27% of staff, as 13 of 48 (the full staffing compliment) were no longer employed in the centre, for various reasons. The high staff turnover was having a negative impact on residents. For example, one resident told the inspector that her favourite staff had left.

**Judgement:**
Compliant
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

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

Report Compiled by:

Sheila McKeivitt
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Outcome 04: Records and documentation to be kept at a designated centre

Theme:
Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents records were not always kept in a safe and secure place.

Action Required:
Under Regulation 22 (1) (ii) -(iii) you are required to: Keep the records listed under Schedule 3 (records in relation to residents) and Schedule 4 (general records) up-to-date and in good order and in a safe and secure place.

Please state the actions you have taken or are planning to take:
All staff has been informed of the breach that occurred on the day of the inspection and of their individual responsibility to ensure that offices and are made secured when leaving the room. The magnetic device has been removed from the door to ensure that...
the door automatically closes when the nursing staffs leave the room.

Proposed Timescale: 20/06/2014

Outcome 07: Health and Safety and Risk Management

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The details of precautions put in place to control risks were not always clearly identified.

Action Required:
Under Regulation 31 (2) (a) and (b) you are required to: Ensure that the risk management policy covers, but is not limited to, the identification and assessment of risks throughout the designated centre and the precautions in place to control the risks identified.

Please state the actions you have taken or are planning to take:
A full review of all risk assessments is currently underway to ensure that all precautions put in place to control risks are clearly identified in each document. This review is being carried out in conjunction with the Nursing Staff, Health & Safety Officer and the organisations external Health & Safety Advisors.

Proposed Timescale: 31/08/2014

Theme:
Safe Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The practice of giving out hot cups/mugs of drinks with no side-table facility for resident did not promote safety and increased the risk of injury to residents.

Action Required:
Under Regulation 31 (4) (a) you are required to: Take all reasonable measures to prevent accidents to any person in the designated centre and in the grounds of the designated centre.

Please state the actions you have taken or are planning to take:
Nests of Tables are now in place for used by the residents during refreshment rounds. Hostess staffs have received re-training in relation to their role and the Health & safety risks to Residents.

Proposed Timescale: 20/06/2014
**Outcome 09: Notification of Incidents**

**Theme:**  
Safe Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
The chief inspector had not been notified of all allegations of staff misconduct.

**Action Required:**  
Under Regulation 36 (2) (f) you are required to: Give notice to the Chief Inspector without delay of the occurrence in the designated centre of any allegation of misconduct by the registered provider or any person who works in the designated centre.

**Please state the actions you have taken or are planning to take:**  
The New person in charge has been made aware of his responsibility to notify the Chief inspector of allegations of misconduct of staff. The HR policy has been updated to ensure full compliance in the future.

**Proposed Timescale:** 14/08/2014

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**Outcome 10: Reviewing and improving the quality and safety of care**

**Theme:**  
Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The system in place did not review all aspects of quality of life or quality of care provided.

**Action Required:**  
Under Regulation 35 (1) (b) you are required to: Establish and maintain a system for improving the quality of care provided at, and the quality of life of residents in, the designated centre.

**Please state the actions you have taken or are planning to take:**  
The Organisation is currently undertaking a review of its internal audit system; this includes a review of the audits in place and analysis of the outcome information for each audit and the design and introduction of additional audits to cover all aspects of the quality of care and life within the centre.

**Proposed Timescale:** 31/12/2014
Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that residents or their representatives were consulted with about the quality and safety of care and quality of life provided to residents.

Action Required:
Under Regulation 35 (3) you are required to: Consult with residents and their representatives in relation to the system for reviewing and improving the quality and safety of care, and the quality of life of residents.

Please state the actions you have taken or are planning to take:
The organisation will continue to hold its monthly Residents meetings, which Relatives and Representatives are welcome to attend, at which time information and feedback is exchanged on all aspects of life in the Nursing Home including the quality of care and life.

The Organisation has a quality feedback form to encourage Residents and Relatives to give any feedback to the management team on all aspects of life in the Nursing Home.

Included in the review as outlined above the organisation is currently reviewing its audit system to allow more detailed analysis of audit findings, these findings will be shared with the Residents and Relatives as part of the Nursing Home annual review.

Proposed Timescale: 31/12/2014

Outcome 11: Health and Social Care Needs

Theme: Effective Care and Support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that alternative non restrictive methods of care were not been tried prior to restraint been used.

Action Required:
Under Regulation 6 (3) (b) you are required to: Provide a high standard of evidence based nursing practice.

Please state the actions you have taken or are planning to take:
The Organisation is fully committed to working towards a restraint free environment in line with the national guidelines. A full review of the use of restraint commenced immediately following the inspection. This includes a review of an auditing tool, necessary equipment identified and a review of the individual needs of each resident.
Improvements will be implemented as they are identified during the review process. Once the review is complete at the end of September 2014 a full action plan to address outstanding improvements required will be drawn up in October 2014.

The restraint policy is currently being reviewed in line with the national guidelines to reflect changes in practice identified as part of the review.

**Proposed Timescale:** 31/10/2014

**Theme:**
Effective Care and Support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Each identified need did not have a corresponding care plan in place.

**Action Required:**
Under Regulation 8 (1) you are required to: Set out each resident’s needs in an individual care plan developed and agreed with the resident.

**Please state the actions you have taken or are planning to take:**
A full Care plan review and re-design is currently underway. The organisation has appointed an external consultant to re-design the current structure to ensure Residents needs can more easily be identified.

As part of this review each individual care plan will be re-assessed and all levels of clinical staff will receive a level of additional training relevant to their individual learning needs.

The policy on documentation has been reviewed to reflect any changes in practice identified.

**Proposed Timescale:** 30/09/2014

**Outcome 12: Safe and Suitable Premises**

**Theme:**
Effective Care and Support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An adequate amount of alternative devices to restraint were not available to meet the needs of residents' living in the centre.

**Action Required:**
Under Regulation 19 (3) (n) you are required to: Make suitable adaptations, and provide such support, equipment and facilities, including passenger lifts for residents,
may be required.

**Please state the actions you have taken or are planning to take:**
The Organisation is fully committed to working towards a restraint free environment in line with the national guidelines. A full review of the use of restraint commenced immediately following the inspection. This includes a review of an auditing tool, necessary equipment identified and a review of the individual needs of each resident.

Alternative equipment is currently being sourced as identified in the audit and will be purchased in line with the response to outcome 11 by the 31st October 2014.

**Proposed Timescale:** 31/10/2014  
**Theme:** Effective Care and Support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The size and layout of the ten bedded room was not adequate to meet the needs of residents' living in this room.

**Action Required:**  
Under Regulation 19 (3) (f) you are required to: Ensure the size and layout of rooms occupied or used by residents are suitable for their needs.

**Please state the actions you have taken or are planning to take:**  
The Nominated Person on behalf of the Registered Provider submitted plans for the re-design of the HDU unit to the authority as part of the re-registration process. These plans include the re-modelling of areas within the nursing home to replace the 10 bedded HDU with single en-suite rooms. Planning has been submitted at the time of writing this response.

**Proposed Timescale:** 31/12/2015  
**Theme:** Effective Care and Support  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
An adequate number of assistive equipment such as beakers were not available to meet the needs of residents'.

**Action Required:**  
Under Regulation 19 (6) (b) you are required to: Provide for the storage of food in hygienic conditions.
Please state the actions you have taken or are planning to take:
As per the nutrition policy the nutritional committee meet every month to discuss each resident. These meetings are minuted. Any equipment identified as required for individual residents at these meetings is ordered immediately using the organisations purchasing policy.

A stock of beakers and adaptive cutlery is now in place for use as identified following clinical needs assessment.

On the day of the inspection no resident was identified as requiring assistive table ware or beakers. Some residents who would have previously used beakers are now using normal cups as advised from the Speech and Language therapist following swallowing assessments.

The residents who required plate guards had those in place.

Proposed Timescale: 20/06/2014

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear if anyone was independently reviewing complaints made to date.

Action Required:
Under Regulation 39 (10) you are required to: Make a person available, independent to the person nominated in Regulation 39(5), to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 39(5) maintains the records specified under Regulation 39(7).

Please state the actions you have taken or are planning to take:
In the absence of the person in charge, where a complaint has been dealt with by the person nominated to act on behalf of the provider, these complaints have been independently reviewed by the Management Committee on a 6 weekly basis.

The complaints procedure and statement of purpose has been updated to reflect this.

Proposed Timescale: 30/07/2014
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person nominated as the complaints officer in the complaints policy was not the person investigating all complaints.

Action Required:
Under Regulation 39 (5) you are required to: Make available a nominated person in the designated centre to deal with all complaints.

Please state the actions you have taken or are planning to take:
As is the current policy the nominated person to deal with general complaints from relatives and staff is the person in charge. The policy has been changed to reflect the following: in the absence of the person in charge general complaints will now be dealt with by the clinical nurse manager deputising for the person in charge.

As per the current policy complaints regarding Elder abuse are managed by the person nominated to act on behalf of the provider and although this is set out clearly in the Elder abuse policy it is now reflected in the complaints policy and the statement of purpose.

In relation to complaints relating staff, or issues arising from conduct or performance these are dealt with in line with the Organisations HR policy and staff handbook. The person in charge remains the complaints officer however in line with the policies named above, the person in charge may if appropriate appoint a suitably qualified member of the management team to carry out any investigation pertaining to conduct or performance. The Complaints policy and statement of purpose has been updated to reflect this.

Proposed Timescale: 30/07/2014

Outcome 14: End of Life Care

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents receiving end of life care did not have the choice of a single bedroom.

Action Required:
Under Regulation 14 (2) (d) you are required to: Identify and facilitate each residents choice as to the place of death, including the option of a single room or returning home.
Please state the actions you have taken or are planning to take:
The Organisation is fully committed to providing a high standard of End of Life Care. As part of the campus development planned for 2015, plans have been drawn up to include a dedicated End of Life Care room.

**Proposed Timescale:** 31/12/2015  
**Theme:**  
Person-centred care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Adequate arrangements were not place to meet the physical needs of the dying resident as the residents level of pain was not been assessed.

**Action Required:**  
Under Regulation 14 (2) (a) you are required to: Provide appropriate care and comfort to each resident approaching end of life to address his/her physical, emotional, psychological and spiritual needs.

Please state the actions you have taken or are planning to take:  
As part of the care plan review all supporting documentation including risk assessments and ongoing monitoring tools are also being reviewed. In the interim an appropriate pain assessment tool is now in place.

**Proposed Timescale:** 30/09/2014  
**Theme:**  
Person-centred care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Staff did not have adequate training in place to ensure they could implement the end of life policy.

**Action Required:**  
Under Regulation 14 (1) you are required to: Put in place written operational policies and protocols for end of life care.

Please state the actions you have taken or are planning to take:  
As part of its commitment to improve End of Life Care the Organisation is committed on an ongoing basis to ensuring that all staff receive the relevant level of training in end of life care.

In addition to the training already completed by staff in the first half of the year, further end of life care training took place in July to include a range of grades of staff ensuring that the required standard of care is being met whilst the remainder of the staff are
being trained in the second half of the year.

| Proposed Timescale: 31/12/2014 |