<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Drumbear Lodge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000132</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Cootehill Road, Monaghan.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>047 84 800</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@drumbearnursinghome.ie">info@drumbearnursinghome.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>Drumbear Lodge Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Dymphna MacMahon</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Siobhan Kennedy</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>50</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</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 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 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 2 day(s).

The inspection took place over the following dates and times
From: 19 November 2014 10:30
To: 19 November 2014 19:30

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

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<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection
This was the seventh inspection of the centre by the Authority and was in response to an application by the provider for renewal of registration of the designated centre. The inspectors reviewed pre-inspection questionnaires received by the Authority, met with residents, staff and relatives, observed practice, reviewed documentation and assessed progress with completion of the action plans developed from findings of the last inspection in August 2014. Feedback received from residents and relatives was, in the main, positive and satisfaction was expressed with the services and care provided.

The inspectors observed that staff engaged with residents positively and respectfully on the day of inspection. Residents spoken with were complimentary of the staff team and expressed satisfaction with the care they received to support their needs.
The inspectors spoke with residents, the provider, person in charge and staff members. The inspectors observed practices and reviewed a sample of residents’ documentation such as care plans, medical records, policies and procedures, incident log, directory of residents, staff training records and duty rotas among others.

Arrangements were in place to ensure infection control and prevention responsibilities and standards were met.

During the course of the inspection, the inspectors discussed the layout and design of areas of the premises with the provider that required improvement to ensure residents’ privacy and dignity needs were met as described in the centre’s statement of purpose. These areas included a multioccupancy room and some twin room accommodation. The mealtime arrangements did not facilitate all residents to dine in the dining room.

Following this inspection, the provider forwarded a plan to the Authority detailing restructuring of the multi occupancy room as the completion date will extend beyond July 2015.

Governance and management arrangements had been strengthened since the last inspection in August 2014 however, the system in place to review and monitor the quality and safety of care and quality of life of residents required further improvement to ensure all areas of deficit were identified and actioned with positive outcomes for residents.

Some areas of fire safety and risk management required improvement. Inspectors found evidence to indicate that further staffing review was required to ensure the staffing skill levels and skill mix was adequate to meet the needs of residents. While a training programme was in place, some staff had not attended mandatory training requirements including protection of vulnerable persons, fire safety procedures and participation in fire drills.

Documented records to be maintained in the centre as required in schedules 2, 3, and 4 and 6 of the regulations was not adequate and found to be in major non-compliance with the legislation.

Prescription for crushing of medication and input by the pharmacist supplying residents' medications did not meet legislative requirements on this inspection. Policies to inform practice in the centre were available and were reflected in practice.

Some residents assessed needs were not informed by a care plan. Review of a sample of residents' care documentation did not provide adequate evidence to support the level of some residents' participation in the social programme resulted in positive outcomes for them. There was inadequate information to support the involvement of residents and/or their significant other in care plan reviewing procedures.

Residents had access to GP and allied health professional expertise to support their needs.
The action plan at the end of this report identifies areas where improvements are required 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.
**Outcome 01: Statement of Purpose**

*There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
As part of the application to renew the registration of the designated centre, the provider was required to submit a statement of purpose for the designated centre. Inspectors reviewed the Statement of Purpose dated 09 October 2014 and found that it contained the required information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and was reflective of the actual services provided to residents.

There was a change of purpose referenced for the 6 bedded multi occupancy room from a high dependency facility since the last inspection in August 2014. The inspectors reviewed the dependency levels of residents residing in this room and determined that the change of purpose accurately reflected the care needs of residents residing there.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**

*The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.*

**Theme:**
Governance, Leadership and Management

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

Findings:
There was a clearly defined management structure that identified the lines of accountability and authority. The provider and person in charge worked full-time in the centre and managed its day to day operation together. There were management systems in place for monitoring some key aspects same including clinical care. However, improvement was required to ensure all areas requiring improvement were identified and addressed.

There was evidence that weekly and monthly safety inspections/audits were carried out and findings were reviewed at monthly health and safety meetings. Some action plans had been developed and were revised to include details of the actions taken, completion timescales, outcomes and delegation of a person responsible for completion of same since the last inspection. This facilitated appropriate tracking of improvements determined/made. There was a schedule of auditing in place including monthly accident and incident review, maintenance audits, an annual pharmacy audit, infection prevention and control and an end of life care audit among others. However, as found on the last inspection, not all deficits were identified and where identified were not all followed through to completion on the day of inspection. In addition there continued to be inconsistent development of quality improvement plans identifying the actions to be taken, timescale and the person responsible for completing same. In addition the impact of some twin rooms and the multi occupancy room were not evaluated from the residents' perspective to ensure their privacy, dignity, independence and safety were not adversely impacted upon. The inspectors were told by the provider that a summary report on quality and safety reviews was being developed for availability at the end of the year.

Inspectors found evidence to support a review of staffing levels and skills was required to ensure residents social care and supervision care needs were met. Staff training also required improvement to ensure staff were enabled to provide contemporary evidence based care to meet residents’ nursing and social care needs. These findings are discussed further in outcome 18.

There were also actions which the provider advised would be completed prior to this inspection which were found to be not satisfactorily completed by inspectors. These actions are described in the relevant outcomes in this report and are repeated in the action plan at the end of this report.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. 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:
Governance, Leadership and Management

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

**Findings:**
Inspectors found that there was a residents’ guide available to inform residents of the services available to them. There was also information displayed at various points around the centre to keep residents informed.

A sample of agreed resident contracts was reviewed by inspectors. The following information was found to be inadequate on this inspection and requires review;
- Additional charges to residents who required carer escort to accompany them to home or to out-patient appointments were not detailed.
- Residents with arrangements in place for periods of one to one support including charges for physiotherapy services and other allied health professionals was not clearly specified.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The person in charge of the centre is Caroline McAree. She was appointed in this role in August 2010. She is a registered general nurse with An Bord Altranais agus Cnáimhseachais na hÉireann. She has experience in caring for older people as required by the Legislation. The person in charge has worked in a clinical management role in her previous employment in the role of person in charge.

The person in charge demonstrated that she was engaged in the governance, operational management and administration of the centre on a consistent basis. The person in charge was knowledgeable about individual resident’s needs and their individual choice however needs to demonstrate application of best practice in terms of resident restraint and consent. Residents knew the person in charge and the inspectors observed residents consulting with her.

During this inspection the person in charge demonstrated that she was aware of the Regulations, the Authority’s Standards and her responsibilities as person in charge of the
The person in charge is supported in her role by the provider who is a registered nurse. The provider deputises in the absence of the person in charge and a team of nursing staff, care assistants, catering, administrative and ancillary staff. The person in charge facilitated the inspection; information was easy to retrieve and was managed with appropriate attention to security of residents' personal information.

**Judgment:**
Compliant

### Outcome 05: Documentation to be kept at a designated centre

The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 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 2013.

### Theme:
Governance, Leadership and Management

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

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

### Findings:

Of the sample of staff records reviewed, inspectors confirmed that the files contained all of the information as required in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The designated centre maintained a directory of residents which did not contain all of the necessary information as specified in Schedule 3 Paragraph (3).

A restrictive practice log was not maintained in the designated centre to reference use of bedrails that restricted residents' access and did not include all of the information required in Schedule 3 Paragraph (4) (g).

Each medication to be given in crushed format was not individually signed by a medical practitioner in the relevant prescription records reviewed as required in Schedule 3 Paragraph 4 (d).

The staff duty rota document was not a complete record of all staff working with residents in the centre on the day of inspection as required by Schedule 4 Paragraph 9.

A training record for all staff recorded on the duty rota was not maintained as required by Schedule 4 Paragraph 8 (c).
As required by regulation 22 and part of the application to renew the registration of the designated centre the registered provider submitted evidence of insurance against injury to residents or/and loss/damage of their property.

**Judgment:**  
Non Compliant - Major

### Outcome 06: Absence of the Person in charge

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

**Theme:**  
Governance, Leadership and Management

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

**Findings:**  
The provider and person in charge were aware of their responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during an absence greater than 28 days. The arrangement in place is that the provider would assume the role of person in charge in the event of the person in charge being absent for more than 28 days. The person in charge had not been absent from the centre for more than 28 days to date.

**Judgment:**  
Compliant

### Outcome 07: Safeguarding and Safety

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

**Theme:**  
Safe care and support

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

**Findings:**
Incomplete information in the policy informing response to allegations of abuse was the subject of an action plan from the last inspection. The inspectors reviewed the policy on this inspection and found that this action was satisfactorily completed following revision to include referral details of the elder abuse social worker and procedures for staff to take if an allegation is made against a senior member of staff. All staff spoken with by inspectors on the days of inspection were knowledgeable regarding procedures for protection of vulnerable residents including their reporting responsibilities. Staff training in elder abuse prevention, recognition and management was facilitated every two years. Three staff had not completed refresher this training in protection of vulnerable adults as per staff training records given to inspectors on this inspection. Some staff last completed this training in 2013. This finding was not in line with recommendations of the National Standards which indicates annual review of implementation of the policy should be taken.

An allegation of abuse was reported to the Authority in October 2014. The inspectors reviewed the documentation which evidenced comprehensive investigation with appropriate actions taken to safeguard residents. Residents spoken with told inspectors they felt safe in the centre. The entrance and exit doors were secure yet accessible to residents. A visitors log was in use to monitor the movement of persons in and out of the building which the inspectors observed to be completed. The inspectors observed staff-resident interactions on the days of inspection and found them to be caring, respectful and supportive throughout.

Management of residents’ finances was reviewed on this inspection. A policy on security of residents' accounts and personal property was available to inform practice. The provider facilitates safekeeping six residents’ day to day expense accounts and is an agent for collection of five residents' social welfare pension. The inspectors viewed the transactions of a sample of residents' day to day expense accounts and found them to be transparent with accurate balances. All transactions were receipted and double-signed.

The provider acted as agent for collection of five residents' pensions. While this arrangement on behalf of residents was informed by the documented policy information, details of same were not included in the residents' contract of residency documentation.

The inspectors found that there were a number of documented incidents involving a small number of residents who experienced episodes of challenging behaviour which impacted on the safety of other residents as evidenced in the records of incidents. Some staff spoken with in relation to care of these residents described triggers to the behaviours and proactive strategies that they implemented to prevent or de-escalate the behaviour. However this information was not comprehensively documented in care documentation to ensure all staff implemented effective proactive strategies to ensure positive behavioural support for these residents and mitigate potential for risk of injury to others. 29% (20) staff were recorded as having received training in crisis prevention management, however no member of staff was recorded as having received training in management of challenging behaviour. Two staff members received training in care of residents with dementia care needs in 2013. This finding is discussed further in outcome 18.

A number of residents were using bedrails with protective bumpers. Review of residents’
documentation by inspectors provided evidence that individual assessments had been completed for bedrail use. Assessments referenced that use of all bedrails by residents was for the purpose of enabling their mobility while in bed. However, the equipment used was not suitable for this purpose as residents' independent access out of their beds was restricted because bedrails extended the full length of the beds and residents could not disengage them independently. This was not in line with the Nation restraint policy. The provider advised inspectors that she was reviewing alternative equipment that was more suited to the purpose of enabling residents while resting in bed. Low-low beds, foam mats and sensor equipment was in place for residents at risk of falling out of bed. This finding is discussed in outcome 8 of this report.

**Judgment:**
Non Compliant - Moderate

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**Outcome 08: Health and Safety and Risk Management**

The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

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

**Findings:**
The inspectors found on this inspection that health and safety of residents, visitors and staff was generally protected including evacuation of residents in the event of a fire occurring in the centre on this inspection. On the last inspection of the centre in August 2014, personal evacuation risk assessments were not completed for each resident to determine personnel and equipment requirements for their safe evacuation in the event of a fire in the centre. In addition fire drill documentation, staff fire safety training and the fire policy required improvement. These areas were the subject of action plans following the last inspection. The inspectors found that each of these areas had been satisfactorily completed. There was evidence of learning with evaluation of effectiveness of evacuation equipment in terms of safety and comfort of residents and time taken to complete the simulated evacuation drills. Evacuation sheets were fitted on each resident’s bed to assist with evacuation if required.
A comprehensive fire prevention checking procedure was in place. Service records of fire safety equipment including the fire alarm were in place.

The staff training records given to inspectors indicated that fire safety training was provided twice annually. The records referenced that two staff on leave had not completed fire training for 2014. The person in charge advised that fire training would be provided for these staff on their return to work. Inspectors found that some staff were not clear on the procedures to follow in the event of the fire alarm sounding and evacuation of residents as appropriate. On this inspection, inspectors observed that a
designated fire exit was obstructed by the location of a dining table and chairs in the dining room. This finding was brought to the attention of the provider who stated this finding would be addressed as a priority.

The centre’s safety statement was reviewed on 18 November 2014. The Risk Assessment Policy informs risk management in the centre and includes policy information on the items set out in regulation 26(1). Weekly safety inspections of the centre were completed which informed the proceedings of monthly health and safety meetings. These meetings were minuted and were reviewed by inspectors. The minutes of the health and safety meetings were reviewed by inspectors and found to evidence comprehensive review of risks found with timely remedial actions taken. There was evidence that unassessed risks identified on the last inspection in August 2014 and which were the subject of a concomitant action plan were satisfactorily completed on this inspection. There was also evidence of further identification of risks with controls stated to mitigate level of risks found. For example, a fracture was noted on the surface of a control switch on a hoist during a weekly safety audit with a resultant action of purchase of a new hoist. Non-functioning wheels on a resident’s bed were replaced. However, inspectors found on this inspection that while identified risks were documented, controls in place for some risks were not adequate to mitigate the level of risk found and included;
- water reservoir located to the front of the centre with some parts of the fencing identified as a control measure were breached
- arrangement in place for resident seating including location of assistive chairs during a music entertainment session for residents in the sitting room posed risk of injury to residents moving around the room from assistive equipment used by others. This arrangement hindered access to some residents by staff in the event of emergency assistance being required
- there was an absence of grab rails in some en suite showers and along side of toilets. Portable chair type raisers were placed over some toilets which posed a risk of overbalance to residents.

Since the last inspection, revision of policy information to inform incident identification, reporting, investigation had been completed in response to a repeated action plan following the last inspection in August 2014. Inspectors found that there was evidence of learning from this process being applied in practice. For example, inspectors noted that resident falls had been reduced by 28% in 2014 in comparison to incidences recorded for 2013. On the last inspection, improvement was required in response to findings of inadequate neurological assessment of residents who sustained a head injury or had an unwitnessed fall in addition to review of findings that 50% of accidents from January to end of July 2014 occurred between 21:30 and 02:30hrs, one of which included a serious injury to a resident. The inspectors found that neurological assessment was part of the physiological assessment of residents following a head injury from falling on this inspection. A review of staffing levels by the person in charge confirmed that there was adequate staffing levels and skill mix to meet the needs of residents during the period 21:30 and 02:30hrs. Further assessment of residents at risk of falling was put in place with input from the physiotherapy service. Auditing of resident falls was completed on a monthly basis to ensure falls management plans were effective in mitigating assessed falls risks.
There were measures in place to control and prevent infection including hand hygiene gel dispensing units at convenient locations throughout. Staff were observed to observe hand hygiene practices as appropriate on the days of inspection. There were three residents with confirmed communicable infections on the days of inspection. A colour coded flat mopping procedure was in place for cleaning floors and cloths for surface cleaning reflected evidence based infection prevention and control standards. Cleaning staff spoken with were knowledgeable in relation to infection control and prevention.

**Judgment:**
Non Compliant - Moderate

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### Outcome 09: Medication Management

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

**Theme:**
Safe care and support

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

**Findings:**

Written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents were in place which was updated since the last inspection in August 2014. Adequate procedures including storage were in place for management of controlled medications as required. Controlled medications were stored in a locked cupboard within a locked cupboard and separate from other medications. A twice daily checking schedule was recorded by two staff on each occasion. Controlled medications were dispensed on a named person basis only as required.

Transcription of medications was undertaken by registered nurses in the centre. An action plan forwarded to the provider following the last inspection in August 2014 in relation to inadequate medication management policy information to inform prescription transcription practice was satisfactorily completed.

Inspectors examined a sample of medication prescription sheets and administration records on this inspection. The medication prescription sheets examined were current. The inspectors found that each resident’s medication was reviewed regularly by residents’ GPs. However, a number of the medication prescription sheets examined did not contain a signature for each medication to be given in ‘crushed’ format. Therefore, these prescription orders were not complete authorisations to administer medications as per the Medicinal Products (Prescription and Control of Supply) Regulations (Amendment) 2007. This finding is discussed in outcome 5 of this report.

Medications for residents were supplied by a local community pharmacy. There was inadequate evidence of appropriate involvement by the pharmacist in accordance with regulation 29 and guidance issued by the Pharmaceutical Society of Ireland including...
quarterly review of prescribed medicine therapy in conjunction with nursing staff and the resident’s GPs. While medication audits were completed by staff in the centre, there was inadequate evidence of pharmacy involvement in this process.

Residents’ photographs were clear and fixed on each prescription for the purposes of checking procedures during medication administration. Drug allergies, date of birth and each resident’s GP details were recorded. Medication administration was observed to be in line with professional standards.

Judgment:
Non Compliant - Moderate

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**Outcome 10: Notification of Incidents**

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

**Theme:**
Safe care and support

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

**Findings:**
A record of all incidents including incidents to residents was maintained in the centre. Quarterly notifications and notifications of serious injury had been submitted to the Authority as required and within the appropriate timeframe but did not include details of bedrail use which were recorded as ‘enablers’ but found on inspection to restrict resident access from their beds. The person in charge was aware that she was legally obliged to notify the Chief Inspector of incidents such as serious injury to a resident or an outbreak of infection which was satisfactorily completed.

Judgment:
Non Compliant - Moderate

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

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

**Theme:**
Effective care and support
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Each resident had care plans developed from assessment of their needs. The inspectors reviewed a sample of care plans and care documentation. A variety of assessment tools were used to evaluate residents’ progress and to assess levels of risk for deterioration. For example, vulnerability to falls with corresponding actions to take in response to level of assessed risk, dependency levels, nutritional risk assessment and moving and handling assessments which were updated every four months thereafter. A pressure related skin damage risk assessment tool in use did not include information to inform level of risk as reflected by the score calculated and did not adequately inform care as required by regulation 6(1).

While, there was evidence that care plans were reviewed by staff, there was inadequate evidence of involvement of the resident or their significant other and a record of which, if any care plans were amended following this process. This finding was subject to an action plan following the last inspection in August 2014 and is restated in the action plans with this report. The inspectors found that some resident needs did not have a documented care plan in place. For example one resident had an assessed risk of pressure related skin damage but did not have a care plan developed to inform care to mitigate level of assessed risk.

While some residents' care plans in the sample reviewed were personalised, others were not. Resident care plans were in pre-printed format with some individualisation done by addition of some text or/and selection of care interventions from a series of pre-printed care options. Inspectors found that this documentation format limited detail in some resident care interventions to meet individual assessed needs. Care plans were not adequately detailed or personalised to inform care for individual residents with complex care needs. For example activity care plans did not adequately inform this area of resident care. Some residents' care plan documentation was dated as developed in 2009 with various amendments made as outcomes of progress reviews. This documentation required review to comprehensively inform contemporary evidence based care to meet residents' assessed needs.

Residents had adequate documented access to general practitioner (GP) services in addition to specialist services to support their mental health needs where required. Access to allied health care services was reported as available and evidenced in residents' care documentation to meet the diverse care needs of residents. In a sample of records reviewed, the inspectors noted that consultations and assessments with care recommendations were recorded to support referral as appropriate. While no residents required palliative care services on the day of inspection, access to this service was confirmed.

On the day of inspection, the centre facilitated a resident's hundredth birthday celebration. Inspectors observed that one of the two day-rooms usually available to residents was unavailable due to same. This resulted in overcrowding of the main day-room, the implications of which in terms of risk and the comfort of other residents was
not adequately appreciated or pre-assessed on this occasion. However, the provider recognised this and acknowledged that the learning gained from this would be applied to hosting similar events in the future.

Inspectors observed and discussed recreational and social activities with the residents. The television was not within the view of some residents. One resident told inspectors that she liked to watch DVDs but this required taking a television out of a cupboard in the day-room and positioning it on a table so that she could see it.

An activity and social programme was available to residents on six days each week co-ordinated by two activity co-ordinator staff. Many residents were observed to be engaged in recreational activities that interested them on an individual and communal basis. Some residents were involved in painting, reading newspapers and one resident was knitting. A bingo session was facilitated which was popular with a number of residents and a music session hosted by a local musician took place in the evening. Many residents attended this session however, as discussed in outcome 8, the large numbers of residents in attendance in addition to the placement of residents in assistive chairs posed risks to the safety of residents in attendance due to congestion and significantly reduced accessibility. Many residents joined in with singing and some residents engaged in dancing with staff. Residents who remained in their bedrooms were provided with options including hand massage, newspaper and poetry reading facilitated by the activity co-ordinators or other staff. The activities that took place on the day of inspection reflected the activity programme schedule as displayed. There was evidence from inspectors' discussions with some residents that they were making choices about the parts of the programme they attended. However, some residents said they preferred to watch and listen rather than participate and others told inspectors that they couldn't participate in activities they liked due to their limited motor dexterity secondary to their medical conditions. The inspectors found that staff spoken with were knowledgeable regarding residents' past interests and hobbies.

Each resident, including residents who chose to remain in their bedrooms had an activity assessment in place; however, these assessments were not comprehensive in that they did not adequately evaluate each resident’s capability to ensure they were facilitated to participate in activities that meet their individual interests and needs. Care staff were involved in evaluating residents' recreational activity needs on a day to day basis. This was evidenced by documentation in daily progress notes. However, as there was an absence of documented individual interventions to meet each resident’s assessed capability and interests, these evaluations did not adequately inform whether participation in scheduled activities resulted in positive outcomes for individual residents as part of their social care needs.

This finding is repeated from the last inspection in August 2014. Inspectors confirmed that activity co-ordinators had not attended accredited training in activity facilitation for residents with diverse care needs including dementia and acquired brain injury. This finding is also discussed further in outcome 18.

There were two residents under 65 years of age with a medical diagnosis of acquired brain injury. There were tailored plans of care developed and implemented for these residents that met their care and activation needs.

**Judgment:**
**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. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Effective care and support

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

**Findings:**
Residents’ accommodation in the centre is provided at ground floor level throughout. During the course of the last inspection in August 2014, the inspectors discussed an existing six bedded, multi occupancy room and the layout of some twin rooms in terms of meeting the privacy and dignity needs of residents residing in them with the provider and person in charge. Since the last inspection the provider had forwarded a plan to the Authority to restructure the six bedded multi occupancy room as completion of this work will extend beyond July 2015. On this inspection, the inspectors reviewed the twin rooms and found that the layout of some twin bedrooms did not adequately meet the privacy and dignity needs of some residents especially those with increased dependency needs. Inspectors observed that bed screen privacy curtains did not provide adequate space when closed for dependent residents to undertake personal activities in private. Access to en suite facilities was hindered due to the position of beds in some bedrooms.

Some resident equipment servicing records were not current as required by regulation 17 (2).

The multi occupancy bedroom accommodates six residents and with an en suite shower, toilet and wash basin provided. Glass window panels are fitted in the wall between this room and a corridor on each side of the entrance door to the room. While, the inspectors observed that curtains were fitted and were closed during residents’ personal care activities on the day of inspection, this finding did not ensure the privacy needs of residents were assured. The layout of this accommodation was clinical in style and did not ensure that each resident had adequate private space which they could personalise. Most residents in this area had no personal shelf space other than the top of their lockers or wardrobe for displaying or storing their personal items. One television was available for viewing by the six residents which did not promote personal choice or autonomy. The purpose of this bedroom was changed since the last inspection from a high dependency unit which is referenced in the centre's statement of purpose document.
The size and layout of the dining room and dining arrangements did not ensure each resident could dine in the dining room as discussed in outcome 15. While there was a system in place with use of containers to segregate clean and soiled clothing/linen, worktop space for this purpose was not provided as recommended by the National Standards.

The inspectors discussed the layout of some twin bedrooms which required review to ensure they meet the needs of residents and are in compliance with the Regulations and Standards. The inspectors observed that the space available inside bed screens to provide appropriate care for residents using assistive equipment such as chairs and/or hoists was limited. In addition, residents could not access en-suite facilities in some twin rooms without encroaching into the personal space of the other resident especially when bed screening was closed for privacy or/and personal care activities. The provider had made some positive changes to improve the layout of some twin bedrooms since the last inspection.

The premises were visibly clean. Adequate cleaning, sluicing and laundry facilities were provided with access controlled by keypad locks. There were two sitting rooms and one dining room, all of which were used by residents. However due to prior arrangements, one sitting room was not available to residents and resulted in the other sitting/day room being congested and overcrowded. This finding posed a risk to residents as discussed in outcome 12. Residents had access to a secure courtyard. Assistive equipment was provided to meet the assessed needs of the residents including standing and lifting hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. However, there was inadequate assistive grab rails provided in some en-suite showers and toilets as discussed in outcome 8.

Maintenance arrangements were reviewed on this inspection. A full-time member of staff carried out maintenance of the centre. There was a procedure in place for identifying maintenance issues including faults which was signed-off on completion. This arrangement facilitated quality assurance and identification of areas requiring review. Service records for equipment used by residents were reviewed by inspectors however; some equipment serving was not current. For example, the weighing scales had not been calibrated since 14 June 2012 as per records available.

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

### Findings:
There was a complaints procedure in place in the centre. Actions required to update the policy following the last inspections were satisfactorily completed. An independent appeal process was in place.

The inspector reviewed the centre's complaints log and observed that there were two complaints referenced for 2014. Both complaints were processed in line with the policy information with the exception of documentation to ensure the complainants were satisfied with the outcome. The majority of residents expressed their satisfaction with the service. Residents spoken with in relation to their satisfaction with the complaints process confirmed that they knew who to make a complaint to and felt they would be listened to.

### Judgment:
Substantially Compliant

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### Outcome 14: End of Life Care

*Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.*

### Theme:
Person-centred care and support

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

### Findings:
Inspectors were told by the person in charge that there were no residents in receipt of end of life care on the days of this inspection. A review of a sample of residents' care plans evidenced that their end of life wishes were discussed and documented where they wished to disclose this information. Members of the local clergy from the various religious faiths provide pastoral and spiritual support to residents who are at the end stage of their lives. There was a policy document available to inform residents' end of life care in the centre. Palliative care services were available on referral to assist with promoting residents' comfort needs. The person in charge stated staff were receiving education and support in ensuring residents were facilitated to make decisions about their end of life care. Fifty one staff had attended training on end of life care to date. In addition six staff attended training on management of medication pumps for administration of medication in palliative care. A small oratory was available to residents which they could spend time in if they wished.

An audit completed in August 2014 on this aspect of residents' care provided positive feedback on progress to the person in charge and provider.
Settlement of fees was not initiated in respect of deceased residents until one month after their death. The centre provides accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time. The person in charge confirmed that residents residing in twin or the multioccupancy bedroom would be provided with single room accommodation at the end stage of their lives. A relative spoken with by inspectors was complimentary of the care provided some time previously for another member of their family at the end stage of their lives in the centre.

Judgment:
Compliant

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

Findings:
There was satisfactory evidence that residents were provided with adequate fluid and dietary intake to meet their needs on the day of inspection. Fresh water was available in each resident’s bedroom and in communal areas. Plain water and water flavoured with an orange concentrate were available at mealtimes. Staff were observed to engage in monitoring and encouraging residents to take fluids. The inspectors found that each resident’s individual nutritional and dietary needs were generally met and that they were offered a nutritious and varied diet that provided them with choice of a hot dish at each mealtime. This choice was displayed. There was no evidence of residents with unintentional weight loss on the day of inspection. The inspectors observed residents at mealtime and found that those that required assistance received same in a dignified and discrete way by adequate members of staff who were assigned to ensure residents were appropriately assisted if necessary.

There was a policy document available to support staff in all aspects of nutritional and hydration care. Residents’ weights were monitored and those identified as being at risk of unintentional weight loss had evidence of monitoring and review by dietetic services. The chef was aware of and accommodated residents with specific nutritional support needs and preferences. The chef had copies of the recommendations made by speech and language and dietetic therapy services which were referenced. Care plans were in place to inform care of residents with nutrition and hydration needs which were satisfactorily linked to monitoring and treatment plans and were evaluated in daily
progress notes.

The dining room accommodated 28 residents with a further 14 residents were served their meals in the day room. The remaining residents ate their meals in their bedrooms. This finding did not support adequate dining room facilities to support all residents to avail of the dining experience in the dining room. This finding is discussed further in outcome 12. Residents spoken with told the inspectors that they enjoyed the food provided in the centre and spoke about the chef in complimentary terms.

**Judgment:**
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 resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
Inspectors were satisfied that residents were enabled to make choices about how they lived their lives in a way that generally reflected their individual preferences and diverse needs. However, mealtime arrangements did not ensure all residents could dine in the dining room and the layout and design of some areas of the premises as discussed in outcome 12 impacted on some residents’ choice. However, the provider is actioning this non-compliance and has forwarded details of a premises restructuring plan to the Authority. Review of full length bedrail used as enablers also required further review to ensure residents' independent access was not restricted.

The layout and design of some twin bedrooms and a multi occupancy room accommodating six residents did not ensure their privacy and dignity needs were met as set out in the centre's statement of purpose and function. The multi occupancy room had glass panels located in the wall between the room and a corridor on either side of the door to this room. Mass was celebrated in the centre's communal sitting room with weekly distribution of communion. There were arrangements in place to ensure the needs of residents of non catholic faiths were also met.

The last residents’ meeting was held in March 2014 and this forum was suspended as residents were not interested in attending. The provider advised inspectors that she valued residents’ feedback and input in the running of the centre. Residents' meetings
were scheduled to reconvene in December. These meetings would be chaired by the activity coordinators and would be minuted. Independent access to an internal courtyard was in place to facilitate vulnerable residents with safe access outside the centre. An advocate was available to residents to support them to make informed decisions about areas that impacted on them.

There was a communication policy in use to inform communication strategies especially for residents who had illnesses and medical conditions that resulted in them having communication deficits. The inspectors observed that residents had access to local and national newspapers. Some residents were observed independently reading them and others who were unable to do so were informed of the contents as part of the communal and one to one activities facilitated by the activity coordinator. The location of the television in the sitting room/day room in conjunction with seating arrangements required review to ensure residents could view same with ease. Residents had access to optical and auditory services and some residents wore glasses and hearing aids. Items of interest to residents were displayed in the centre for their information.

As discussed in outcome 11 of this report, there was inadequate documentation to inform whether participation in social and recreational activities had positive outcomes for residents in terms of meeting their interests and capacities as required by regulation 9 (2)

The centre also had a telephone which residents could use if they wished to speak to relatives in private. Residents’ confirmed that they had regular visitors and could choose where they would like to meet them. A quiet room with comfortable seating was available in addition to the two sitting rooms.

Judgment:
Non Compliant - Moderate

**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.*

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

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

**Findings:**
The inspectors found that not all residents had adequate space to store their clothes and personal belongings. Residents in the multioccupancy room and in some twin rooms did
not have adequate space to store their personal belongings. One resident residing in a twin room expressed dissatisfaction with this and advised inspectors that this was being addressed by the provider with her relocation to a single room when one became available. Due to the layout and design of some twin rooms not all residents had access to their personal wardrobe space without entering the personal space of another resident in twin rooms including when bed screen curtains were closed.

There was a policy to inform management of residents' personal property and possessions available. A record of each resident’s property was completed but was completed to ensure possessions were recorded. Residents spoken with told inspectors that they never lost any possessions in the centre. The centre has a laundry on-site and residents clothing was laundered by designated staff. Linen collection skips were available that appropriately segregated used linen in line with the national policy. While segregation of clean and soiled linen/clothing was done with use of containers, a worktop was not available in the laundry for this purpose as recommended by the National Standards. This finding is discussed in outcome 12. Residents spoken with told the inspectors that their clothing was managed to their satisfaction. The inspectors observed that clothing worn by residents was clean, in good condition and stored neatly in wardrobes and drawer units. Items of residents clothing viewed by the inspectors had the residents identification on them.

Judgment:
Compliant

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**Outcome 18: Suitable Staffing**

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.*

**Theme:**
Workforce

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

**Findings:**
Since the last inspection, the provider and person in charge completed a review of the adequacy of staffing and with enhancement of falls prevention management was satisfied that staffing levels and skill mix was adequate. Inspectors assessed staffing levels and skill mix on the day of inspection and found that further review was required. Inspectors observed a short period during the morning of the inspection where a
A student on work experience was supervising 31 residents in the day-room. In addition, the inspectors observed that the staff member facilitating activities was also involved in providing care to residents which interrupted activity facilitation for residents.

Inspectors reviewed staff training records. Mandatory training for staff was the subject of an action plan following the last inspection and was not satisfactorily completed as evidenced by findings on this inspection. Three staff had not attended refresher training on protection of vulnerable adults in 2013/2014. This training was facilitated every two years which did not include reference to arrangements for annual review of implementation of the policy on protection of vulnerable adults. Two staff members did not have documented attendance at fire safety training in 2014. Some staff spoken with were not adequately informed on the procedures to follow in response to the fire alarm sounding as described in the centre's fire policy. This finding is discussed in outcome 8. Staff facilitating activities for residents had not attended accredited training to inform their practice in this area. This area of resident care was found to require improvement on this inspection. There were residents residing in the centre with dementia care needs and with episodes of challenging behaviour that impacted on the safety of other residents in the centre. However, inspectors found that two staff had attended training in dementia care in 2013 and no staff had attended training in proactive management of challenging behaviour.

On the day of inspection, the inspectors reviewed the staffing rota. Annual leave and other planned/unplanned staff absences were covered from within the existing staffing complement and with the support of an identified 'relief' team which provided continuity for residents. The inspectors found that pre-nursing students on work experience were not recorded on the staffing rota given to inspectors. In addition two care staff recorded as working on the duty rota were not documented on staff training records. Full names of catering staff were not referenced in the duty rota. The hours of duty of all staff with the exception of nursing staff, the person in charge and the provider were not entered on the staff rota using a 24-hour clock format. This finding is discussed in outcome 5.

Staff were observed to practice safe moving and handling procedures and the person in charge told the inspectors that all staff had completed mandatory training in this area. However, not all mandatory training was completed by staff. The training records evidenced that two staff had not completed elder abuse training.

Residents interviewed were complimentary of the staff team and expressed satisfaction with the care they received to support their needs. The inspectors found staff spoken with to be knowledgeable of their roles and responsibilities regarding residents’ care and preferences.

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

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
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

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Drumbear Lodge Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000132</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>19/11/2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19/03/2015</td>
</tr>
</tbody>
</table>

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While there were management systems in place, some audits/reviews did not adequately identify all areas of deficit or where areas of deficit were identified, actions to be taken and timescales for completion to ensure that the service provided is safe, appropriate, consistent and effectively monitored with positive outcomes for residents.

Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
ensure that the service provided is safe, appropriate, consistent and effectively monitored.

**Please state the actions you have taken or are planning to take:**
Going forward all audits conducted in the home will have an action plan, to include the following:
- Faults identified
- Location
- Person Responsible
- Timescale
- Date control implemented

**Proposed Timescale:** 19/11/2014

### Outcome 03: Information for residents

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Two residents did not have contracts in place referencing the terms and conditions of their residency including fees, signed and agreed by them or their next of kin on their behalf.

**Action Required:**
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

**Please state the actions you have taken or are planning to take:**
New contracts of care have been issued to the above two resident’s next of kin with the above required information included.

**Proposed Timescale:** 19/03/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Additional charges to residents who required carer escort to accompany them to home or to out-patient appointments were not detailed. Residents with arrangements in place for periods of one to one support including charges for physiotherapy services and other allied health professionals was not clearly specified in contracts.

**Action Required:**
Under Regulation 24(2)(a) you are required to: Ensure the agreement referred to in regulation 24 (1) relates to the care and welfare of the resident in the designated centre and includes details of the services to be provided, whether under the Nursing Homes Support Scheme or otherwise, to the resident concerned.

**Please state the actions you have taken or are planning to take:**
Contracts have been renewed to include the above required information.

**Proposed Timescale:** 19/03/2015

<table>
<thead>
<tr>
<th>Outcome 05: Documentation to be kept at a designated centre</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> The designated centre maintained a directory of residents which did not contain all of the necessary information specified in Paragraph (3) of Schedule 3 in some resident details entered including address of next of kin, address and telephone number of GPs and cause of death.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 19(3) you are required to: Ensure the directory includes the information specified in paragraph (3) of Schedule 3.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Directory of residents reviewed and the necessary information as specified in Paragraph (3) of Schedule 3 inserted.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong> 19/03/2015</td>
</tr>
<tr>
<td><strong>Theme:</strong> Governance, Leadership and Management</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong> All records required by schedules 2, 3 and 4 of the regulations were not maintained as required.</td>
</tr>
<tr>
<td><strong>Action Required:</strong> Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong> Full review of Schedules 2, 3 and 4 to be conducted to include any omissions of</td>
</tr>
</tbody>
</table>
Proposed Timescale: 22/05/2015

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not attended training to ensure they had up to date knowledge and skills to respond to and manage residents with dementia care needs and behaviour that is challenging.

Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
1. In-house training on Dementia to be carried out for all staff to update their knowledge and skills in this area.
2. The PIC will review training records to identify staff that requires training in the area of Challenging Behaviour with the aim of ensuring all staff are trained in this area.

Proposed Timescale: 19/05/2015

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Positive behavioural support documentation for residents with challenging behaviour did not adequately describe triggers to the behaviours, proactive strategies to be implemented and de-escalation strategies.

Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
The PIC together with Nursing Staff will review residents who display behaviour that challenges to ensure care plans include triggers to the behaviours, proactive strategies to be implemented and de-escalation strategies.
**Proposed Timescale:** 31/12/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Assessments referenced that use of all bedrails by residents was for the purpose of enabling their mobility while in bed. However, the equipment used was not suitable for this purpose as residents' independent access out of their beds and was not in line with the National restraint policy.

**Action Required:**
Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

**Please state the actions you have taken or are planning to take:**
We are currently in the process of researching and sourcing half bed rails that are compatible with our existing profiling beds and compliant with legislation. When we have sourced a half bed rail to meet residents needs and legislation we will reassess all residents who are currently using bed rails in the home with the view of reducing bed rail usage further.

Proposed Timescale:
To commence immediately to include a trial period of the new product when sourced

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**Proposed Timescale:** 19/11/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Three staff were not recorded as having completed refresher training in protection of vulnerable adults as per staff training records given to inspectors on this inspection

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

**Please state the actions you have taken or are planning to take:**
Of these three staff, two were on maternity leave and one carer was on long term sick leave post surgery.

Proposed Timescale:
Training to be updated as soon as they return to work
## Proposed Timescale:

**Outcome 08: Health and Safety and Risk Management**

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Safe care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>While identified risks were documented, controls in place for some risks were not adequate to mitigate the level of risk found.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 26(1)(b) you are required to: Ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.</td>
</tr>
</tbody>
</table>
| **Please state the actions you have taken or are planning to take:** | Going forward all audits conducted in the home will have an action plan, to included the following:  
- Faults identified  
- Location  
- Person Responsible  
- Timescale  
- Date control implemented. |

<table>
<thead>
<tr>
<th><strong>Proposed Timescale:</strong></th>
<th><strong>19/11/2014</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
<td>Safe care and support</td>
</tr>
<tr>
<td><strong>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Inspectors found that some staff were not clear on the procedures to follow in the event of the fire alarm sounding and evacuation of residents as appropriate.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>Fire training will be carried out within the next four weeks as per routine for all nursing home staff with emphasis on fire prevention and emergency procedures, including</td>
</tr>
</tbody>
</table>
 evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

### Proposed Timescale: 19/12/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A designated fire exit was obstructed by the location of a dining table and chairs in the dining room.

**Action Required:**
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

**Please state the actions you have taken or are planning to take:**
This was addressed immediately on the day of inspection.
All staff are aware that fire exits are to remain unobstructed at all times.

### Proposed Timescale: 19/03/2015

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was inadequate evidence of appropriate involvement by the pharmacist in accordance with regulation 29 and guidance issued by the Pharmaceutical Society of Ireland.

**Action Required:**
Under Regulation 29(2) you are required to: Facilitate the pharmacist concerned in meeting his or her obligations to a resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland.

**Please state the actions you have taken or are planning to take:**
The PIC will arrange a meeting with the Pharmacist to discuss his obligations to residents in the home under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland. We will then devise a plan to meet this outcome.
### Outcome 10: Notification of Incidents

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Quarterly notifications did not include details of bedrail use which were recorded as ‘enablers’ but found on inspection to restrict resident access from their beds.

**Action Required:**
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

**Please state the actions you have taken or are planning to take:**
Going forward details of bedrail use will be recorded and included in the quarterly notifications.

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### Proposed Timescale: 19/11/2014

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### Outcome 11: Health and Social Care Needs

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was inadequate records to evidence involvement/consultation of residents or their significant other in care plan reviews including if any care plans were amended following this process.

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

**Please state the actions you have taken or are planning to take:**
The PIC will conduct a review/audit of all care plans with a view to ensure that all residents and or Nok are included in care plan reviews.

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### Proposed Timescale: 19/02/2015

**Theme:**
Effective care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all residents' assessed needs were informed by a care plan. Residents did not have adequate assessments and care plans to ensure their recreational care needs were met and which reflected their capabilities and interests.

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

Please state the actions you have taken or are planning to take:
The PIC will conduct a review/audit of all recreational care plans with the Activities Coordinators with a view to ensure that all residents’ recreational needs are met. This review will also take into account the residents capabilities and interests.

Proposed Timescale: 19/01/2015
Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Progress evaluations did not adequately inform whether participation in scheduled activities resulted in positive outcomes for individual residents as part of their social care needs.

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

Please state the actions you have taken or are planning to take:
The PIC will conduct a review of how the resident’s participation in recreational activities are currently assessed and documented in the home. A plan will be implemented to ensure that positive outcomes for individual residents as part of their social care needs are met and documented accordingly.

Proposed Timescale: 19/01/2015
Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A pressure related skin damage risk assessment tool in use did not include information
to inform level of risk as reflected by the score calculated and did not adequately inform care.

Some care plans were dated 2009 and were in pre-printed format which limited individualisation and did not ensure they reflected contemporary evidence based care information.

**Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnámhseachais.

**Please state the actions you have taken or are planning to take:**
1. The skin damage risk assessment tool currently in use will be reviewed to ensure that it includes the score calculated to adequately inform care.
2. The PIC will conduct a review/audit of all care plans with a view to ensure that all residents care plans are in date and individualised to reflect evidence based care.

**Proposed Timescale:** 19/01/2015

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**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:**
The layout and design of some twin rooms and a multi occupancy room did not adequately meet the privacy and dignity needs of some residents especially those with increased dependency needs as described in the statement of purpose.

There was inadequate dining room accommodation to facilitate each resident with a choice of dining in the dining room.

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

**Please state the actions you have taken or are planning to take:**
- A) Additional 12 bed extension with dining room.
- B) On completion of the new build, the multi occupancy room will be converted to two twin rooms with ensuite facilities.
- C) All twin rooms will be assessed to ensure that the resident’s privacy and dignity needs are met.

**Proposed Timescale:**
• We hope to have a) and b) completed by December 2015.
• Assessments on these rooms have commenced already and we aim to complete these as soon as possible.

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:
Aspects of the premises did not conform to the requirements of Schedule 6 of the regulations to meet the needs of residents.

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:
a) Maintenance of equipment: All residents weighing scales have been serviced since inspection. Going forward this shall be done on an annual basis or more frequently if required.
b) Curtain rails surrounding resident’s beds: Since inspection position and layout of all curtain rails in twin rooms have been reviewed and alterations carried out to meet the resident’s privacy and dignity. These alterations now allow free movement around the room for residents and staff, and unobstructed access to wardrobes and ensuites.
c) Glass window panels on 6 bedded window panels: These glass panels will be fitted with privacy film to enhance residents privacy at all times until such time the 6 bedded is converted as discussed in management plan. On construction of these two bedded rooms the glass panels in question will be completely removed.
d) Assistive Grab Rails: We have spoken to a local Occupational Therapist and asked her to conduct an assessment of the ensuite showers and toilets in the nursing home.

Proposed Timescale:
a) Actioned b) Actioned c) 2 weeks. d) 23rd March 2015.

Proposed Timescale: 23/03/2015

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:
There was no record maintained to reference whether complainants were satisfied with the outcome of investigation.

**Action Required:**
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
Record of whether complaints were satisfactorily dealt with will be added to the complaints book.

**Proposed Timescale:** 19/03/2015

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

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was inadequate documentation to inform whether participation in social and recreational activities had positive outcomes for residents in terms of meeting their interests and capacities.

**Action Required:**
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

**Please state the actions you have taken or are planning to take:**
Recreational documentation will be reviewed by the PIC with the Activities Coordinators and Nursing Staff to include positive outcomes for residents in terms of meeting their interests and capacities.

**Proposed Timescale:** 20/04/2015

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Mealtime arrangements did not ensure all residents had a choice to dine in the dining room.

**Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.
Please state the actions you have taken or are planning to take:
• There are two dining room facilities in the nursing home.
• The main dining room caters for residents who can interact with each other and do not require assistance. There are available spaces in the main dining room to facilitate resident’s choice as to where they want to have their meals on a daily basis.
• The back sitting room contains an established dining area. There are two circular tables where residents in wheelchairs and assisted chairs can dine at. Residents that require assistance with their meals are accommodated in this dining area.
• Any resident that dines in their bedroom do so as a result of personal preference or request.

Proposed Timescale:
• An audit will be conducted to ensure residents dining preferences are accommodated.
• One month.

Proposed Timescale: 19/12/2014
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Glass window panels fitted in the wall between a multi occupancy room and a corridor on each side of the entrance door to the room did not ensure residents privacy needs were met.

The privacy and dignity needs of residents were not adequately met due to the design and layout of some twin bedrooms and a multi occupancy bedroom.

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

Please state the actions you have taken or are planning to take:
Glass window panels on 6 bedded window panels: These glass panels will be fitted with privacy film to enhance residents privacy at all times until such time the 6 bedded is converted as discussed in management plan. On construction of these two bedded rooms the glass panels in question will be completely removed.

Proposed Timescale: 03/12/2014
Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to the seating arrangements in the sitting/day room all residents who wished to could not view the television.

**Action Required:**
Under Regulation 09(3)(c)(ii) you are required to: Ensure that each resident has access to radio, television, newspapers and other media.

**Please state the actions you have taken or are planning to take:**
- All residents who wish to have a TV in their bedroom are accommodated. There is a large screen TV in the “Green Room“ and in the”reading room”. Both are connected to DVD players. Residents who wish to watch TV can do so in these two sitting rooms and in their bedrooms

**Proposed Timescale:** 19/03/2015

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**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staffing levels and skill mix required review to ensure the needs of residents were met as appropriate.

**Action Required:**
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

**Please state the actions you have taken or are planning to take:**
Since inspection staffing levels were discussed at a meeting between the provider, PIC and Senior Care Assistants.
It was highlighted at this meeting that there was a need to improve staffing levels between 16.30 and 18.00hrs. The nursing home has accommodated this request by providing an additional care assistant between the hours in question. Feedback has been very positive.

**Proposed Timescale:** 19/03/2015

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**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some staff had not completed mandatory training.
Some staff had not completed training to inform meeting the complex needs of residents including challenging behaviour, dementia care and activity provision.

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

**Please state the actions you have taken or are planning to take:**
1) The only staff that did not receive mandatory training were staff that were on: A) Maternity leave x1 and extended maternity leave x1, and b) Long term sick leave x1.
2. In-house training on Dementia to be carried out for all staff to update their knowledge and skills in this area.
3. The PIC will review training records to identify staff that requires training in the area of Challenging Behaviour with the aim of ensuring all staff are trained in this area.
4. One of our Activity coordinators is returning from maternity leave at the end of March. She is trained to the required level for her role. On her return we will look into up skilling the second Activity coordinator.

Proposed Timescale:
1) This will be actioned as soon as the staff in question returns to work.
2) And 3) to be actioned within 6 months.
4) Within one academic year.

**Proposed Timescale:** 19/05/2015

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Pre-nursing students were not appropriately supervised.

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

**Please state the actions you have taken or are planning to take:**
- Pre-nursing students work alongside registered nurses and care assistants. Students may perform some tasks in an environment where they can observe other employees performing skilled or professional jobs, thus gaining insight into what the work entails.
- PIC will review supervisory roles of nursing staff and care assistants for work experience students.

**Proposed Timescale:** 19/03/2015