<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Bethany House Nursing Home</th>
</tr>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000015</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Main Street, Tyrrellspass, Westmeath.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>044 922 3391</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@bethanyhouse.ie">info@bethanyhouse.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>MPM Nursing Home Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Madeline Corboy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Jillian Connolly</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Catherine Connolly Gargan</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents</td>
<td>32</td>
</tr>
<tr>
<td>Number of vacancies</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 3 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tr>
<td>22 October 2014 10:30</td>
<td>22 October 2014 19:00</td>
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<tr>
<td>23 October 2014 07:30</td>
<td>23 October 2014 14:30</td>
</tr>
<tr>
<td>30 October 2014 12:00</td>
<td>30 October 2014 18:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Statement of Purpose</th>
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<tr>
<td>Outcome 02: Governance and Management</td>
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<tr>
<td>Outcome 03: Information for residents</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
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<td>Outcome 05: Documentation to be kept at a designated centre</td>
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<td>Outcome 06: Absence of the Person in charge</td>
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<td>Outcome 07: Safeguarding and Safety</td>
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<td>Outcome 08: Health and Safety and Risk Management</td>
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<td>Outcome 09: Medication Management</td>
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<td>Outcome 10: Notification of Incidents</td>
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<td>Outcome 11: Health and Social Care Needs</td>
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<td>Outcome 12: Safe and Suitable Premises</td>
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<td>Outcome 13: Complaints procedures</td>
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<td>Outcome 14: End of Life Care</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
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<tr>
<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
</tr>
<tr>
<td>Outcome 17: Residents' clothing and personal property and possessions</td>
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<td>Outcome 18: Suitable Staffing</td>
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Summary of findings from this inspection

The designated centre is a nursing home located in Co. Westmeath. The centre has capacity for 32 residents. The purpose of the inspection was following an application by the provider to renew the registration of the nursing home under the Health Act 2007.

On the day of inspection there were 29 residents residing in the designated centre, fourteen male and eighteen female. Three residents had been temporarily discharged to an acute setting. Eleven residents were assessed as being maximum dependency, seven residents were assessed as having a high dependency and eight residents
were assessed as requiring medium support. The remaining six residents were assessed utilising an evidence based tool as having low support needs. Sixty percent of residents had a cognitive impairment such as Alzheimer’s Disease or Dementia. The designated centre places emphasis within the Statement of Purpose and Function the importance of socialization and creating a homely environment. Inspectors confirmed that this ethos is translated into practice.

Inspectors met with residents and staff, reviewed documentation and observed practice. As part of the application to renew the registration of the designated centre, questionnaires were provided to the residents and relatives to complete. Six relative questionnaires were returned to the Authority and four questionnaires from residents. The feedback in the questionnaires was positive with residents stating that they feel safe and well cared for with one resident stating that staff were ‘exceptional’. Relatives stated that they were satisfied with the care their loved one received and that they were informed and consulted regularly. All relatives stated that they had never had a reason to complain.

Compliance was identified in six of the 18. There were seven moderate non-compliances identified, however there was a common theme throughout all of the moderate non-compliances which related to the documentation of residents needs and relevant interventions to meet that need, inadequacies in the policies and procedures and an absence of clinical audits or an overall review of the quality of services provided which informed improvements in practice. The policies and procedures have previously been identified as a failing in a report published by the Authority in November 2011.

Four major non-compliances were identified. Significant failings in respect of the premises been previously identified in reports dated November 2011, October 2012 and October 2013 due to the presence of a three bedded room which inspectors determined is not fit for purpose, an absence of the appropriate number of bathrooms and the suitability of the visitors’ room. The provider has submitted plans to the Chief Inspector for an extension which proposes to increase the capacity of the centre to 54. Inspectors reviewed the plans with the provider and confirmed that they include the appropriate number of bathrooms and an accessible visitors’ room. The provider was awaiting confirmation of planning permission as of the day of inspection.

Health and Safety and Risk Management was also deemed majorly non-compliant as not all hazards in the designated centre had been assessed and appropriate control measures implemented which had been previously identified in November 2011 and October 2012 following on from inspections by the Authority. Major non-compliance was also identified in the privacy and dignity of residents in the three bedded room which had been identified in November 2011, October 2012 and October 2013.

Twenty four breaches of regulation were identified on inspection, eighteen of which are the responsibility of the registered provider and six the responsibility of the person in charge. Considering the cumulative failings identified in this report and the absence of a review of the quality and safety of care of residents, major non-
compliance was identified in Outcome 2, Governance and Management.

The action plan at the end of the report identifies areas where mandatory improvements are required in order to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
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 and determined that it contained the 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.

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):
No actions were required from the previous inspection.

Findings:
As stated in Outcome 18, inspectors determined that there was adequate staff to meet the residents’ needs during the day however evidence did not support that staffing levels were sufficient at night. The failings identified on this inspection, identified
deficits in the resources available to ensure effective governance and management as required by Regulation 23. The application to renew the registration of the designated centre stated that there are three people involved in the management of the designated centre, a director who is also the person in charge/provider nominee, a second director and the deputy person in charge. The statement of purpose further states that the hours the management team are employed in the centre equates to one and half whole time equivalents. Inspectors determined that this was inadequate and did not facilitate the provider to achieve compliance with the Health Act 2007 and Regulations. There are two directors of the company, one employed directly within the designated centre, the person in charge. The second director was not recognised on the roster, however inspectors were informed that when available they were involved in the governance and management tasks such as policy development. The person in charge was also the provider nominee who was employed from 9.00 – 17.00 hours Monday to Friday. 9.00 – 12.00 was documented on the roster as being ‘on floor management’ and 12.00 - 17.00 was documented as being ‘off floor’ management therefore demonstrating the person in charge had twenty five hours per week for administrative tasks and reviewing the quality and safety of care. From a review of rosters the deputy person in charge is employed for providing care directly to residents and was always rostered as the nurse on duty with no protected time for management duties. The Statement of Purpose and Function states that the nursing home is dedicated to providing the highest standard of nursing care and residents will have a safe and secure surroundings. The evidence obtained on this inspection identified inconsistencies in the planning of care for residents and the management of risk. The provider had not completed a review of the quality and safety of care delivered to residents to ensure that the care is in accordance with the relevant standards as set out in Section 8 of the Health Act 2007 and approved by the Minister of Health under Section 10 of the Health Act 2007.

Inspectors identified a deficit in clinical audits such as the use of restrictive practice, wound care management, residents’ plans of care and a qualitative review of falls. The designated centre had recently commenced utilising an electronic system for maintaining records. The systems allowed for management to capture quantitative information regarding the pre–mentioned information however there was no evidence that this information was analysed and utilised to improve practice. The deficits identified in the policies further evidenced that the time allocated to governance and management was inadequate. Overall based on the findings of this inspection 18 breaches in the regulations relate to the responsibility of the provider and 6 are the responsibility of the person in charge, inspectors concluded that the governance and management requires immediate review.

Judgment:
Non Compliant - Major

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 reviewed a sample of contracts for the provision of services and confirmed that each resident had written agreement in place. However inspectors found that the contract did not sufficiently identify the services to be provided within the designated centre and the exact fees to be paid. For example, there were residents who had initially been admitted as private residents and had subsequently been approved for assistance under the Nursing Home Support Scheme, however the contracts had not been amended to reflect same, therefore it was not clear the fees that the resident was personally responsible for. In other instances the fees to be paid were not stated. The contract listed a number of services which the resident may receive within the weekly fee however it was not clear what services were actually included. For example, transport was stated as a service which may or may not be included. There was evidence that residents had been charged additionally for transport however there was no evidence that it had been agreed on admission and the fee to be charged in the event of this occurring. Inspectors requested that the provider review all residents’ contracts during the feedback meeting.

The designated centre had a guide available to residents which included a summary of the services and facilities in the designated centre, the procedures in respect to complaints and the arrangements for visits. However the terms and conditions relating to residence in the designated centre were not present as required by Regulation 20 (2) (b).

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 designated centre is also the person nominated by the designated centre as the provider. The person in charge is a registered nurse. Inspectors reviewed documentation confirming that their registration was current. The person in charge is employed on a full time basis and is solely employed in carrying on the business of the designated centre and has been involved in the running of the
designated centre since 2006. The person in charge demonstrated that they are engaged in the governance, operational management and administration of the designated centre. However as stated in Outcome 2 inspectors were not assured that the person in charge had sufficient protected time to engage in the operational management and administration of the designated centre. Inspectors observed that residents were aware of the person in charge and residents confirmed that they were available to meet with residents regularly.

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 stipulated in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The designated centre had transferred six months prior to the inspection to maintaining residents’ records in an electronic format. The designated centre maintained a directory of residents which contained all of the necessary information specified in Paragraph (3) of Schedule 3 such as the date on which the resident was admitted to the designated centre and the date on which the resident was discharged. Inspectors determined however that the records maintained in respect of Paragraph (4) of Schedule 3 required improvements as there were inconsistencies in the accuracy. For example, as stated in Outcome 11, information was recorded by members of staff whose role was not appropriate to be documenting such information. There was a nursing record maintained on a daily basis however in some instances the nursing staff signing the record was not on duty at the time of entry. The provider stated during feedback that this was due to staff learning to utilise the electronic system and they were neglecting to sign in or out. There was also an absence of plans in relation to specific nursing care required or the administration of medication as required or health care needs which had been identified in the progress note of residents. While there was a restrictive practice log maintained
in the designated centre t did not include all of the information required in Schedule 3 Paragraph (4) (g).

The designated centre maintained a record of the fees that had been charged to residents as stipulated in Schedule 4, however there were improvements required in the records maintained in respect of residents’ finances, which are evidenced in Outcome 7. There was a complaints log maintained, with the last complaint being recorded in 2012. There was also a directory of visitors maintained.

Whilst there was policies in place, inspectors determined they did not consistently inform of practice and were not informed by evidence based practice and were not reviewed every 3 years as required by Regulation 4 (3). The provider had recently reviewed the policy in relation to medication management and End of Life Care which reflected evidence based practice and legislation. However the policy in relation to the use of restraint referenced that the only forms of restraint utilised in the designated centre were bedrails and safety belts on wheelchairs, whilst as stated in Outcome7 this was not reflective of practice. There was a policy regarding the prevention and management of falls. It did not reflect evidence based practice. For example, it did not refer to the re-assessment of a resident’s risk of falls following a fall.

As part of the application to renew the registration of the designated centre the registered provider submitted evidence of insurance against injury to residents.

**Judgment:**
Non Compliant - Moderate

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**Outcome 06: Absence of the Person in charge**
*The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
A senior staff nurse was designated as the person to deputise in the absence of the person in charge. There had been no instances since the initial registration of the designated centre that the person in charge had been absent from the designated centre for more than 28 days therefore the registered provider did not have to give notice of same to the Chief Inspector. However the provider demonstrated awareness of the requirement as stipulated in Regulation 32.

**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):**
No actions were required from the previous inspection.

**Findings:**
The designated centre had a policy in place regarding the prevention, detection and response to elder abuse which had been reviewed in October 2014. Of the sample of staff files reviewed, staff had received the relevant training in Elder Abuse. Staff spoken to demonstrated knowledge of the actions to be taken in the event of a suspicion or allegation of abuse and the different forms of abuse. Improvements were required in the policy to ensure it was reflective of the designated centre. For example, the policy did not reference the HSE Elder Abuse Officer for the region. It also referred to the role of the ‘operations manager’ however there were no personnel who held that position within the service. Residents spoken to state that they felt safe residing in the designated centre. As stated in Outcome 5, there were improvements required in the records maintained regarding the use of residents’ personal finances. The designated centre offers a service in which residents can maintain small sums of money on site. However the documentation was inadequate regarding the purpose for which the money was utilised. For example, residents were charged monies for social outings however it was not clear in some instances a breakdown of the total cost to the resident, despite residents being charged different sums of money for the same outing. There were also inconsistencies in the documentation of activities for which money was withdrawn occurring. For example, some residents’ paid directly for massage therapy. However on review of their daily notes there was no evidence that the massage had occurred. It was also not clear if the monies were used at the request of the resident or on their behalf. Inspectors discussed this with the provider nominee on the second day of inspection. On return to the designated centre, the provider had developed two draft policies to guide staff in the practice of residents’ finances and determining capacity and consent. The person in charge verbally informed inspectors that staff would be made aware of the policy immediately.

There were residents who were identified as experiencing behaviours that challenge. There was a policy in place regarding the management of behaviours that challenge however improvements were required as it did not reference the appropriate resources available such as referrals to psychiatry or psychology professionals. There was also a policy in relation to the use of restraint. The policy referenced that the only forms of restraint utilised in the designated centre were bedrails and safety belts on wheelchairs. There were key pads on all exits doors which required a code for entering and exiting.
This was as a safeguard due to the location of the centre to a busy road, however was not recognised as a limitation on the freedom of residents movements and in turn a restrictive practice. Inspectors identified residents who were prescribed medication as required as a result of behaviours that challenge. For example, residents had plans of care in place for behaviours that challenge with interventions including administering medication as prescribed and monitor for effectiveness. There was no guidance for staff of the circumstances in which the medication should be administered and alternative strategies to be implemented prior to use of same. Therefore not evidencing that practice was in line with national policy as stated in Regulation 7(3). There was evidence that seven staff employed had received training in behaviours that challenge since 2011.

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

**Findings:**
There was a health and safety policy and risk management policy in place in the designated centre. There was also a communal risk register in place which identified hazards and the relevant control measures in place. However a review was required of the risk register as inspectors identified hazards in the designated centre which had not been assessed. For example, the smoking room for residents was located beside residents’ bedrooms. This had not been assessed and inspectors observed a strong smell of smoke. Inspectors noted that there was a gap of approximately one inch at the bottom of the internal door which was also regularly left open, despite signage instructing to keep closed. There was also an external door leading out from the smoking room which was key padded. Inspectors observed visitors and staff utilising this door regularly to enter and exit the centre and a visitors’ book was present in the room, which was signed regularly, indicating that this was utilised as an exit and entrance into the centre which is not appropriate based on the purpose of the room. The smoking room was not included in the centre risk register. Inspectors also observed that the sitting room was narrow and could not safely accommodate all residents who required specialised equipment. The person in charge stated that they were aware of this risk and subsequently planned activities to ensure that residents could be accommodated safely. This was not assessed in the risk register. The control measures in place did not always reflect the practice of the designated centre. The control measures in place for the hazards associated with slips/trips and falls addressed environmental practices such as cleaning up spillages. There was no reference to clinical practices such as assessing residents’ risk of falls and referrals to the relevant Allied Health Professionals. The risk register also did not sufficiently acknowledge the key pad units in place to secure doors.
For example, in order for entry and egress into the visitors’ room a code was required. This was a control measure as there was a risk to residents due to stairs being beside the room. However if a resident or visitor were unaware of the code they were unable to leave the visitors room without the support of staff, and there was no way of alerting staff of their wish to leave. Each resident had a missing profile documented and there was documented evidence that drills had been undertaken. There was an accident and incident log maintained in the designated centre.

There was a policy in place regarding the management and control of infection. Staff had training in the infection control. The inspector observed adequate hand hygiene practices in place. There was a record of cleaning maintained in the designated centre. Staff spoken to were able to provide the inspector with adequate information required for appropriate practices. For example, the colour coded system in place in respect of the laundry.

As part of the application process for the renewal of registration for the designated centre, the provider is required to submit written confirmation from a competent person that all the requirements of the statutory fire authority are compiled with. This confirmation was submitted to the Authority prior to the inspection. Inspectors also reviewed the records of fire maintenance and confirmed that fire equipment was checked and serviced at appropriate intervals. Of the sample of training records for staff reviewed, staff received training in the prevention and management of fire annually, as per the policy of the designated centre. Staff spoken to were able to inform of the procedures in the event of a full evacuation and the location of the fire exits and the fire assembly points. The centre has a clear policy on the action to be taken in the event of an emergency; however inspectors found that the information displayed throughout the designated centre was not reflective of this procedure and informative to residents, staff and visitors. For example, inspectors were informed that the designated centre was divided into five fire zones. Therefore in the event of an emergency, horizontal evacuation would be required from one zone to another. There was evidence that drills have been conducted however did not adequately inform of the number of residents evacuated, the number of staff present and the actual time it took to evacuate residents, or if the equipment documented as required for each resident in their personal evacuation plans such as ski sheets and wheelchairs were effective. In one zone there were nine residents. The provider had not completed a fire drill evidencing that the two staff on duty at night could evacuate the nine residents considering their personal evacuation plans in an adequate time frame. Prior to inspectors concluding the inspection, they verbally requested that this be completed. Arrangements had been made with a local hotel to accommodate residents in the event of a full evacuation being required.

Judgment:
Non Compliant - Major

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:**
The policy in place regarding medication management had been developed in July 2014. The policy references nurse transcribing by one nurse which is not in line with evidence based practice as there was no reference to a second nurse checking to ensure accuracy. Medication was stored securely and there was appropriate storage for controlled drugs with a system of two nurses signing at the commencement of each shift of controlled medications in stock.

Of the sample of prescription and administration sheets reviewed, inspectors found that they contained all of the necessary information such as the name of the resident, name of the medication, times of administration and there was a signature of the prescriber present for each individual medication. The times of administration recorded on the administration records corresponded with the prescription. There was a record of signatures available for all staff nurses. The maximum dosage for medication as required was also listed on the prescription sheet however as stated in Outcome 7, improvements were required in the instructions for staff in when medications should be administered in response to behaviours that challenge. Medications which were crushed for administration had been prescribed to be administered in this format. Inspectors observed medication being administered and were satisfied that the practices were safe.

There was evidence that monthly medication audits were occurring in conjunction with the pharmacist and actions arising from same were implemented. There had also been one medication error reported to the Chief Inspector through the quarterly notification as required by Regulation 31 (3). Inspectors reviewed the investigation that had been undertaken and were assured that the appropriate actions had been taken and learning for staff had occurred from the findings.

**Judgment:**
Compliant

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

**Findings:**
The inspector reviewed the accident and incident log and confirmed that all appropriate notifications had been submitted to the Chief Inspector within the appropriate time.
Judgment:
Compliant

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

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

**Theme:**
Effective care and support

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

**Findings:**
As stated previously the designated centre had commenced utilising an electronic system for the assessment of residents’ health and social care needs and the development of subsequent plans of care. Daily nursing notes were also documented within the electronic system. Whilst there were assessments in place utilising evidence based tools, improvements were required in the development of the care plans created for the assessed needs. For example, there was a resident assessed as being at high risk of pressure sores however the care plan developed to inform staff of the necessary interventions was generic and did not inform of practice. There was reference to the resident requiring re-positioning without stating how often. There was also reference to residents wearing long sleeves to protect skin integrity however their arms were not an area of risk. There were also deficits in the development of care plans as a result of a change in need, such as resident being re-admitted following a stay in an acute setting. Inspectors were aware that the person in charge was concerned over the health need of a resident however there was no reference to this in the residents’ records or the interventions to meet that need. Care plans for residents who had a diagnosis of epilepsy did not inform of the actual care the resident required. For example, a resident was prescribed medication as required for pre seizure activity and in the event of a seizure however there was no reference to this in their plans of care. As stated in Outcome 4, there was evidence that staff had entered notes into the progress notes of residents who were not of the appropriate skill or were not actually on duty at the time of the entry.

There were weekly audits conducted regarding the clinical needs of residents which reviewed the number of residents who had specific clinical needs such as catheter care, pressure sores, physical restraint or required a review by the General Practitioner however inspectors found that the purpose of the audit was to identify the residents
involved as opposed to assessing the quality and safety of care provided to residents. There was no evidence of outcomes of the audits and improvement in the clinical care as a result of the learning.

Residents had access to Allied Health Professionals and had access to a General Practitioner if required. Inspectors observed a responsive approach to meeting residents' needs by Allied Health Professionals on inspection. Residents maintaining good health were also promoted through the offering of vaccinations for Influenza.

Inspectors found that when residents were temporarily discharged from the designated centre there was a procedure in place to ensure the pertinent information was provided to the receiving designated centre such as the hospital. There was also records maintained of the information obtained from the discharging hospital. Inspectors observed the person in charge communicating with an acute setting regarding the readmission of a resident to the designated centre.

Residents had care plans in place regarding engagement in meaningful activities. The Statement of Purpose for the designated centre states that ‘central to the ideals of nursing care is the concept of socialisation both within and outside of the nursing home.’ Inspectors observed that residents were supported to engage in activities which were meaningful to them and this was reflected in their personal plans. For example, residents who choose not to engage in communal activities had plans in place to guide staff on the residents’ area of interest such as soccer teams. There was a wide range of activities provided to residents and evidence that the activities were planned in consultation with the residents. Activities addressed the cognitive, emotional, spiritual and physical needs of residents; including bingo, a weekly exercise group, mass and music. The centre promotes a homely approach to resident care, with two pets being present, the most recent a puppy following on from the request of a resident. Residents expressed contentment with the activities offered to them and stated that they were occupied throughout the day. There was also evidence of residents being supported to engage in activities in the wider community through social outings. For example, photographs showed residents visiting local historical sites. Residents, who were not at a retirement age, were supported to attend a day service within the community. The designated centre also had a practice of raising turkeys in preparation from Christmas and residents reported enjoyment at participating in their care.

**Judgment:**
Non Compliant - Moderate

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**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:
The nursing home is registered for thirty two residents and located in the centre of a town. Inspectors observed the premises to be homely with pictures of residents throughout the centre. The bedrooms consists of eleven single rooms with a hand basin, four single rooms with an en suite, seven twin rooms with an hand basin and one triple room. There is also a visitors’ room, a kitchen, dayroom/dining area, sitting room, smoking room and office. Inspectors found that the centre was clean and heated appropriately however there was insufficient ventilation in the smoking room which resulted in a strong smell of smoke around residents’ bedrooms. Residents’ bedrooms were personalised with a silhouette picture of each resident on the front of their door. Failings identified in previous reports related to the unsuitability of the locations of the visitors’ room, insufficient bathrooms for residents and the triple room.

As stated in Outcome 7, access to a visitors’ room was via keypad therefore residents cannot access it independently. However once in the visitors’ room it was also not possible to exit without the assistance of staff. Inspectors inspected the triple room and determined that it does not meet the privacy and dignity of the residents’ residing there. The privacy curtains between the beds did not meet. Due to the location of a wardrobe it was not possible to easily utilise the privacy curtain around one bed without disrupting the personal property of the resident. Another bed had insufficient space between the privacy curtain and the bed to engage in personal activities such as dressing and the television was located above the bed of one resident restricting their view of same. The room measured 22.75 m2 meaning that there was 7.6m2 of floor space per resident which is not in compliance with standards. The provider has submitted plans to the Authority to build an extension onto the nursing home for an additional 22 beds. The provider informed inspectors that it is proposed that the extension which was awaiting planning permission as of the day of inspection, will address the non-compliance in relation to the bathrooms and the visitors’ room.

There was appropriate equipment to meet residents’ needs such as grab rails and hoists. The external grounds of the centre contained numerous slopes and access was to a busy road, however this was accounted for in the risk register and as stated previously keypads were utilised as a safeguard. The laundry was maintained in an external wooden structure which had also been risk assessed.

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):
No actions were required from the previous inspection.

Findings:
There was a policy and procedure in place regarding the management of complaints dated January 2012. The procedure was also included in the residents’ guide and displayed on a notice board on the wall. Residents identified the person in charge as the person they would make a complaint to. There was a record of complaints maintained with the last complaint being logged in 2012. There were inconsistencies in the policy and the legislative requirements. For example, the nurse in charge on any given day was nominated as the person with responsibility for dealing with complaints in the procedure however Regulation 34(1) (c) states that the provider nominates a person other than a person involved in the complaint to deal with complaints. In practice that was the person in charge. Furthermore Regulation 34 (3) states that the registered provider will nominate someone other than the person nominated in Regulation 34 (1)(c) to oversee the management of complaints. However it was not clear in the policy which member of the team was responsible for same.

Judgment:
Non Compliant - Minor

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:
The designated centre had a policy in place regarding the end of life care of residents dated February 2014. The policy addressed the physical, social, psychological and spiritual needs of residents. There was documented evidence that each of the residents had been approached by staff regarding their wishes for the end of their life. However there were inconsistencies in the care plans created as a result of these discussions. In some instances the end of life care plans for residents were specific and detailed the exact wishes of residents, it was also clear if a resident chose not to engage in conversation. However in other instances the plans were generic and not reflective of the resident. For example, inspectors observed numerous care plans which were replicas of each other, referencing the use of syringe drivers if necessary. However the assessed needs of residents did not necessitate such an intervention. In other instances reference
was made to supporting the family of the resident in accordance with the wishes of the resident. However the family members were not identified to inform staff of who to contact or in other cases the resident did not have involvement with their family.

The policy referenced the practice of withholding interventions such as resuscitation in the event of a resident’s condition deteriorating. There was evidence that residents had chosen not to be resuscitated and that this decision had been done in consultation with the clinical team and the resident’s family.

Inspectors reviewed a sample of residents’ files who had died and identified that each resident had an end of life care plan in place. However due to deficits in the progress notes it was not possible for the inspector to determine if the end of life wishes of residents had been met. Progress notes referenced the clinical presentation of the resident and if the family was present. They also referenced the time in which the resident was removed from the designated centre to the funeral home, however they did not include if the wishes of the resident had been communicated to the relevant people or carried out.

The designated centre had facilities on the first floor for family members to stay which included a kitchenette, sitting area, bathroom and bedroom. Staff had received training in End of Life Care.

**Judgment:**
Non Compliant - Moderate

### Outcome 15: Food and Nutrition

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

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

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

**Findings:**
The designated centre had a policy on place regarding meeting the nutritional needs of the residents. Residents spoken to stated they enjoyed the food, with one resident reporting it was ‘how her mother used to cook’. Inspectors reviewed a questionnaire which had been undertaken to assess the likes and dislikes of residents and the options available regularly were reflective of the findings. Inspectors joined residents for a meal and found the food to be hot and well presented. There was a choice of a main meal and dessert. There was fresh water and juice available in residents’ rooms and in communal areas and fruit readily available for a snack. Inspectors observed residents being offered hot drinks and snacks outside of main mealtimes.

Staff informed inspectors of the systems in place regarding ensuring residents who
require specialised or modified diets are supported with same. Documentation supported
the information provided by staff. Residents are assessed utilising an evidence based
tool for their nutritional status and have their weight checked monthly. If a resident is
identified as having a nutritional need they are referred to the General Practitioner who
refers the resident to the relevant Allied Health Professional. Residents who are at risk of
malnutrition have their weight checked weekly. The recommendations of the Allied
Health Professional are transferred into the plan of care for the resident and
communicated to the catering staff via a nutritional folder. The inspector observed
residents who required assistance with eating and drinking to be supported in a dignified
manner.

There were residents who required a Percutaneous endoscopic gastrostomy (PEG)
feeding tubes. There were care plans in place for residents in place regarding same and
care plans in relation to oral hygiene and mouth care. Staff had received training in
Nutrition and Hydration, Malnutrition, Management of Swallowing Difficulties, Food
Fortification, Basic Nutrition, Nutrition and Constipation and Nutrition and Diabetes in
2014.

Judgment:
Compliant

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

**Findings:**
Residents spoken to stated that they were consulted and included in the running of the
centre. The Statement of Purpose states that this is done through regular residents
meetings and informally during daily discussions. Inspectors reviewed a sample of
minutes from residents meetings and observed that mealtimes were a daily opportunity
in which staff discussed with residents different aspects of the service. The centre also
produced a monthly newsletter which informed of upcoming events, and reviewed
events that had occurred. There was also a monthly survey completed on a different
topic, for example residents’ favourite movies were included and how residents liked
their eggs cooked. A residents’ survey was conducted in 2014. The designated centre
had a consent policy in place which was dated 2012. The policy stated that if a resident
was unable to make an informed decision it is the responsibility of the nursing staff to
arrange for the resident to be assessed by a suitably qualified professional. However, inspectors found that this did not occur in practice, as there was no clear rationale for when the next of kin was consulted regarding decisions around the care of a resident as opposed to the resident. There was a policy in place which outlined the rights of residents however it did not fully address legislation. For example it did not address the residents’ rights to undertake personal activities in private, which was identified as inspectors as an area requiring improvement in the triple bedded room as result of inadequacies in the privacy curtains.

There was a policy in place regarding communication needs of residents dated July 2014, which addressed residents’ rights to access the media and the procedure regarding residents’ consultation in their care. Residents spoke to informed inspectors of the pertinent areas of their care. For example a resident was able to inform residents of the actions that were taken in respect of their diagnosis of epilepsy. There was a procedure in place regarding referrals to relevant Allied Health Professionals in respect of communication aids if necessary. Residents also had plans of care in place regarding their communication needs.

Inspectors observed numerous visitors in the designated centre throughout the inspection. As stated in Outcome 12, there was a visitors’ room available however it was not independently accessible to all residents. There was a visitors’ book available. The policy regarding the rights of residents reference the right of residents to refuse visitors if they so wished.

**Judgment:**
Non Compliant - Major

**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:**
As stated in Outcome 4, there was a policy in place regarding residents’ personal possessions and finances however the policy did not adequately inform practice. Each resident had a personal locker and wardrobe in their room, however in the triple bedded room there was inadequate space for residents to store their possessions. This was discussed with the person in charge on inspection. There was an inventory of personal belongings completed on residents’ admission into the nursing home. As mentioned previously the laundry was located in the external grounds. Residents’ clothing was individually tagged and this was utilised as a safeguard to ensure residents’ clothes were...
returned to them. Residents’ reported satisfaction with the laundry service.

**Judgment:**
Non Compliant - Moderate

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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):**
No actions were required from the previous inspection.

**Findings:**
Inspectors reviewed a sample of rosters which demonstrated that the staffing levels on the days of inspection were reflective of the actual staffing levels and that stated in the Statement of Purpose. The roster demonstrated that there was always a registered nurse on duty. While residents’ day to day needs were met with the standard staffing level, inspectors determined as stated in Outcome 2 that there was a deficit in the staffing available to ensure that the provider was in compliance with Regulation 23. There was also insufficient evidence that staffing levels at night ensure the safety of residents in the event of an emergency.

Staff were observed engaging with residents in a friendly manner indicative of good relationships. Residents also confirmed that staff were friendly and very helpful.

There was a policy in place regarding training and development which was dated July 2014. Inspectors confirmed that staff had the appropriate training relevant to meeting their role such as statutory training of Manual Handling, the prevention, detection and response to abuse and the prevention and management of fire. Staff had also received additional training in medication management, infection control, nutrition, challenging behaviour, continence promotion and CPR training. From a review of staff files there was records of formal staff supervision which identified areas for staff improvement and learning. Inspectors determined that staff required additional training in respect of the Health Act 2007, regulations and legislation as required by Regulation 16 (1)(c) as staff were not aware of Section 73 (4) of the Health Act 2007.

**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:

Jillian Connolly
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>Bethany House Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000015</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>22/10/2014</td>
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<tr>
<td>Date of response:</td>
<td>14/07/2015</td>
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Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failings identified on this inspection demonstrated that the management structures did not adequately support the effective review of the safety and quality of care provided.

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The provider has increased the number of protected Hours for the PIC to engage in the management and governance of the centre and the deputy has been allocated protected hours to engage and support the PIC in the management of the centre.

The company director participates in the running and management of the centre, these hours are now protected and structured in the roster pattern to further assist the PIC.

A Quality Management System has now been installed. This system gathers all adverse information and data and analyses this to develop opportunities for continuous improvement. The adverse data is fed into a Quality meeting where root cause analysis (RCA) is used to assist the PIC and the provider to identify the cause of problems and to take corrective action to prevent a reoccurrence. The information and data from sources such as audits, complaints, accidents and incidents, reports (HIQA), along with data collected by the nurses on a weekly basis concerning the quality of care is analysed for any trends and possible improvements. This process also provides for the opportunity to produce an annual quality report as required under section 23(d).

A report for 2014 will be compiled.

Proposed Timescale: Quality Management system implemented COMPLETE 01/01/2015
Compilation of 2014 Report 31/07/2015

| Proposed Timescale: 31/07/2015
| Theme: Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no annual review conducted as required in regulation.

Action Required:
Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

Please state the actions you have taken or are planning to take:
A Quality Management System has now been installed. This system gathers all adverse information and data and analyses this to develop opportunities for continuous improvement. The adverse data is fed into a Quality meeting where root cause analysis (RCA) is used to assist the PIC and the provider to identify the cause of problems and to take corrective action to prevent a reoccurrence. The information and data from sources such as audits, complaints, accidents and incidents, reports (HIQA), along with
data collected by the nurses on a weekly basis concerning the quality of care is analysed for any trends and possible improvements. This process also provides for the opportunity to produce an annual quality report as required under section 23(d).

Proposed Timescale: Quality Management system implemented COMPLETE 01/01/2015

Compilation of 2014 Report 31/07/2015

**Proposed Timescale:** 31/07/2015

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was insufficient time allocated by management to ensure that residents received the highest standard of nursing care and the surroundings were safe as per the statement of purpose. Evidence did not support that staffing levels at night were sufficient to safely evacuate residents in the event of an emergency.

**Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
All night duty staff have been trained in the emergency plan and fire training / evacuation techniques and training files were reviewed by inspectors, on the inspector’s request a fire drill simulating night staff levels in Zone 5 will be carried out and timed to ensure safety is being met. Night staff are currently supported with rostered on call local based staff that can be contacted in the event of an emergency. We plan on engaging an independent company with expertise in Fire and risk management to review our systems, for the interim an additional onsite staff will be included on the night roster to assist staff should an emergency arise.

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

**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:**
The residents' guide did not adequately inform of the terms and conditions in which a resident resides in the designated centre.
**Action Required:**
Under Regulation 20(2)(b) you are required to: Prepare a guide in respect of the designated centre which includes the terms and conditions relating to residence in the centre.

**Please state the actions you have taken or are planning to take:**
Any additional costs to residents are clearly communicated and agreed with residents and or their representatives prior to any additional services being supplied, this is done on admission and where necessary post admission by way of phone / verbal and or confirmation in writing e.g hairdressing pricelists. Based on feedback from inspectors, an insert has been prepared for the residents’ guide/contract that itemises and clearly sets out any services which will require an additional charge.

**Proposed Timescale:** 01/12/2014

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear in the contracts agreed between the resident and the provider of the actual service to be received.

**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:**
A new template for contract of care had recently been implemented to reflect the changes in regulations and health act 2007 amended July 2013. The weaknesses identified have now been clarified and contracts clearly states what services are covered within the fee and what will require additional charge.

**Proposed Timescale:** 01/12/2014

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was not clear of the exact fees to be charged for services.

**Action Required:**
Under Regulation 24(2)(b) 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 fees, if any, to be charged for such services.

Please state the actions you have taken or are planning to take:
Based on feedback from inspectors, an insert has been prepared for the residents’ guide/contract that clearly sets out any services which will require an additional charge

Proposed Timescale: 01/12/2014

Outcome 05: Documentation to be kept at a designated centre
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was inconsistencies in the polices as required by Schedule 5. Some polices had not been reviewed within three years. Other policies did not adequately inform evidence based practice.

Action Required:
Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

Please state the actions you have taken or are planning to take:
A complete review has been undertaken of our schedule 5 policies and procedures. These are now fully compliant with the Health Act 2007 and the subsequent changes in July 2014.

Proposed Timescale: 01/12/2014

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The records as required under Schedule 3 were inaccurate and did not fully inform of the actual practices.

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

Please state the actions you have taken or are planning to take:
The transition from paper to the electronic system is now completed and all records set
out in schedule 2, 3 and 4 are now available to inspectors.  
A restrictive log is available.

**Proposed Timescale:** 01/03/2015

### Outcome 07: Safeguarding and Safety

**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Due to the absence of guidance for staff as regards to the appropriate use of medication as required for behaviours that challenge, there was no evidence to demonstrate that restrictive practices were utilised in accordance with evidence based practice.

**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:**  
For residents whom have been prescribed medication in relation to behaviours that challenge all of these care plans have been reviewed and updated with resident specific guidance and information on the use of these medications and the appropriate reviews and multi-disciplinary referrals.

As part of our policy review our policy on Behaviours that challenge includes all the appropriate guidance and information step by step in an evidence based format that better reflects the practices taking place.

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

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

**Theme:**  
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
A review of the risk register was required to ensure that all of the hazards within the designated centre were recognised and adequately assessed.

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

**Please state the actions you have taken or are planning to take:**
A hazard analysis and a risk assessment has been carried out on all environment matters and the suggested action has been implemented by the Home to ensure the safety and quality of life of residents. Hazards and the subsequent risks concerning individual residents have been captured and the mitigating actions identified along with a named person to control these.

A Safety Statement has been prepared and this identifies all hazards and the subsequent risks and staff have been trained to understand and apply its contents.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Not all of the control measures adequately addressed the level of risk present and the actions to be taken.

**Action Required:**
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.

**Please state the actions you have taken or are planning to take:**
A hazard analysis and a risk assessment has been carried out on all environment matters and the suggested action has been implemented by the Home to ensure the safety and quality of life of residents. Hazards and the subsequent risks concerning individual residents have been captured and the mitigating actions identified along with a named person to control these.

A Safety Statement has been prepared and this identifies all hazards and the subsequent risks and staff have been trained to understand and apply its contents.

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Whilst the procedures to be taken in the event of fire were displayed throughout the centre, they did not adequately reflect the structure of the building and the means of escape.
**Action Required:**
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

**Please state the actions you have taken or are planning to take:**
As acknowledged in the report as part of registration the centre had been inspected by a competent fire engineer and a copy of compliance was submitted along with registration documents.

Following feedback from inspector’s additional signage has been put in place and a map of the building showing the various key locations such as fire doors, exit routes, fire alarm points and FFE.

**Proposed Timescale:** 01/12/2014

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drills did not evidence that residents could be safely evacuated at night in the event of an emergency.

**Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**
A fire drill has been carried out by an independent Professional Organization and a report has been carried out indicating the outcomes from the drill, the independent observers of the drill are satisfied at the level of competence displayed by the staff.

**Proposed Timescale:** 10/03/2015

**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 an absence of care plans for some identified clinical needs of residents.

**Action Required:**
Under Regulation 05(3) you are required to: Prepare a care plan, based on the
Assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident’s admission to the designated centre.

**Please state the actions you have taken or are planning to take:**
All Residents clinical needs have been identified and care plans have been put in place within 48 hours of the Residents admission.

**Proposed Timescale:** 01/12/2014

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Care plans created were generic and did not always inform of evidence based nursing care.

**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 Cnáimhseachais.

**Please state the actions you have taken or are planning to take:**
The transition from paper to electronic system is now complete and all care plans for all residents are in place and these are as a result of evidence based assessments.

**Proposed Timescale:** 01/02/2015

**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 following matters did not comply with Schedule 6:
- The three bedded room did not provide adequate private space for residents
- The layout of the three bedded room did not provide sufficient room for storage
- There was insufficient ventilation in the smoking room
- There were insufficient number of bathrooms 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:
The three bedded room will be reduced to a two bedded shared room for compliance. This will be completed ahead of registration.

Following a review it is planned that the smoking room location will be changed as will the location of the visitors room, this will now address the suitability of the location and potential for smoke odour and further addresses the restriction of access due to safety reasons and having a key pad as part of the entry to the current visitors room.

As viewed by inspectors there are comprehensive plans to extend the nursing home which are in the planning application process these address plans the insufficient number of bathrooms. Planning process due to be completed by April 2015

Proposed Timescale:
3 bedded room changed to twin bedroom Complete on 10/07/15

Extension will be completed by 31/12/16

Proposed Timescale: 31/12/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear who the nominated person was to deal with complaints.

Action Required:
Under Regulation 34(1)(c) you are required to: Nominate a person who is not involved in the matter of the subject of the complaint to deal with complaints.

Please state the actions you have taken or are planning to take:
A full review of our complaints Policy and Procedure has taken place and all persons involved in the complaints process have been clearly identified in the P & P.

Proposed Timescale: 17/11/2014

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear who the person was who was nominated to ensure complaints were dealt with in accordance with the policy.
**Action Required:**
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

**Please state the actions you have taken or are planning to take:**
This omission has been rectified in our complaints policy.

**Proposed Timescale:** 10/11/2014

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**Outcome 14: End of Life Care**

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
It was unclear if the wishes of a resident were met at the end of their life due to inadequacies in the documentation.

**Action Required:**
Under Regulation 13(2) you are required to: Following the death of a resident make appropriate arrangements, in accordance with that resident’s wishes in so far as they are known and are reasonably practical.

**Please state the actions you have taken or are planning to take:**
The end of Life Policy and procedure clearly sets out the requirements under Regulation 13 (2) and a review of the outcomes concerning resident’s wishes is carried out after the death of a resident. All aspects of the end of life theme are recorded and audited appropriately to the support the practise which is a very important part of our service.

**Proposed Timescale:** 10/11/2014

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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:**
The three bedded room was not conducive for residents undertaking personal activities in private.

**Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.
Please state the actions you have taken or are planning to take:
The three bedded room will be reduced to a two bedded shared room for compliance. This will be completed ahead of registration.

**Proposed Timescale:** 10/07/2015

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The visitors’ room was not accessible to residents without the support of staff.

**Action Required:**
Under Regulation 11(2)(b) you are required to: Make suitable communal facilities available for a resident to receive a visitor and a suitable private area which is not the resident’s room, if required.

Please state the actions you have taken or are planning to take:
The visitor’s room is now accessible to all residents.

**Proposed Timescale:** 01/02/2015

**Outcome 17: Residents' clothing and personal property and possessions**

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate space for residents in the triple room to store their personal belongings.

**Action Required:**
Under Regulation 12(c) you are required to: Provide adequate space for each resident to store and maintain his or her clothes and other personal possessions.

Please state the actions you have taken or are planning to take:
The three bedded room will be reduced to a two bedded shared room for compliance. This will be completed ahead of registration.

All residents have adequate space to store their clothes and personal possessions.

**Proposed Timescale:** 10/07/2015
**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not clear of the Health Act 2007 and the relevant regulations.

**Action Required:**
Under Regulation 16(1)(c) you are required to: Ensure that staff are informed of the Act and any regulations made under it.

**Please state the actions you have taken or are planning to take:**
All staff have been re issued with the Health Act and training in its contents has now been provided.

**Proposed Timescale:** 01/11/2014