**Health Information and Quality Authority**
**Regulation Directorate**

**Compliance Monitoring Inspection report**
**Designated Centres under Health Act 2007, as amended**

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

| | |
|---|---|
| **Centre name:** | Eliza Lodge Nursing Home |
| **Centre ID:** | OSV-0000663 |
| **Centre address:** | Five Roads,<br>Banagher,<br>Offaly. |
| **Telephone number:** | 057 915 2922 |
| **Email address:** | michael@elizacare.ie |
| **Type of centre:** | A Nursing Home as per Health (Nursing Homes) Act 1990 |
| **Registered provider:** | Eliza Care Limited |
| **Provider Nominee:** | Michael Lyons |
| **Lead inspector:** | Siobhan Kennedy |
| **Support inspector(s):** | Sonia McCague |
| **Type of inspection** | Unannounced Dementia Care Thematic Inspections |
| **Number of residents on the date of inspection:** | 48 |
| **Number of vacancies on the date of inspection:** | 2 |

## About Dementia Care Thematic Inspections

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

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

**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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**

| From: | To: |
|---|---|
| 16 February 2016 11:30 | 16 February 2016 20:00 |

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

| Outcome | Provider's self assessment | Our Judgment |
|---|---|---|
| Outcome 01: Health and Social Care Needs | Substantially Compliant | Non Compliant - Moderate |
| Outcome 02: Safeguarding and Safety | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 03: Residents' Rights, Dignity and Consultation | Substantially Compliant | Non Compliant - Moderate |
| Outcome 04: Complaints procedures | Compliance demonstrated | Compliant |
| Outcome 05: Suitable Staffing | Compliance demonstrated | Non Compliant - Moderate |
| Outcome 06: Safe and Suitable Premises | Substantially Compliant | Substantially Compliant |
| Outcome 07: Health and Safety and Risk Management | | Non Compliant - Moderate |
| Outcome 08: Governance and Management | | Non Compliant - Major |

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection focusing on dementia care.

Inspectors examined the relevant policies and a provider self assessment questionnaire which was received by the Authority on 21 April 2015.

The person in charge completed the provider self-assessment, the self assessment judgments and inspection findings are set out in the table above. The action plan which accompanied the self assessment identified actions and time frames to ensure

full compliance.  These related to having greater involvement from residents and family members in the care planning process, improving activities for residents and signage throughout the premises.

In addtion to the six outcomes which informed the dementia thematic inspection, inspectors also monitored 2 additional outcomes, governance and health and safety. There was no annual review of the quality and safety of care, the risk management policy had not been fully implemented and day-to-day practices did not conform to infection prevention and control standards.

On the day of the inspection there were 48 residents and 2 vacancies. Thirteen residents were assessed as having dementia. There was no specific dementia unit.

Inspectors met with residents, relatives, and staff members, observed care practices and interactions between staff and residents using a validated observation model, reviewed documentation such as care plans, complaints and medical records and information regarding staff working in the centre.

In the main, the healthcare needs of residents were met with the good access to medical and allied healthcare although improvements were also needed in relation to care planning and medication management.

Many of the staff did not have mandatory training in the detection, prevention of and responses to elder abuse and the management of behaviours.

The policy and practice on the use of restraint was in line with the national policy and staff were working to promote a restraint free environment.

In the main, inspectors saw that staff respected the privacy and dignity of residents. On an individual basis the views of residents and their families/representatives were sought, however, there was no formal consultation process to engage residents and their relatives in the organisation of the centre.

Observations by inspectors showed that staff engaged in a meaningful way with the majority of residents. However staff engagement with residents who had dementia, especially those with sensory deficits was an area for improvment.

Staffing levels were appropriate, however, information required in respect of staff working in the designated centre was not available in accordance with regulatory requirements.

The premises had many aspects of good design  which supported residents with dementia. Communal facilities were adequate and appropriately furnished. The bedrooms had ensuite facilities and had ample space. Further improvments were required to provide an environment that maximised the potential of residents with dementia.

The areas of non-compliance are detailed in the action plan of this report.

**Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 01: Health and Social Care Needs***

**Theme:**
Safe care and support

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

**Findings:**
There was evidence that families and residents' representatives were involved in the residents' care plans and review of care. However, there was no evidence of resident involvement. The person in charge had planned to improve involvement of residents in the care planning process.

Residents' records were available and contained copies of discharge letters/correspondence from hospital, however, there was no Common Summary Assessments (CSARS) which detailed the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment prior to discharge.

In respect of residents who were transferred to hospital from the centre inspectors found that the transfer letter contained information about the resident's health, medicines and personal information. Relatives were informed if a resident was transferred to hospital and in the main would accompany the resident, however if this was not possible a staff member would accompany a resident to ensure that full information was provided.

There was evidence of an assessment on admission and ongoing assessments in relation aspects of nursing care. This assessment process involved gathering personal information and using validated tools to assess each resident's risks in specific areas, for example falls, skin integrity, malnutrition, moving and handling and pain.

Care plans were developed based on the assessments and inspectors saw that residents' care plans were formally reviewed on a 3 to 4 monthly basis. This was carried out by nursing staff who coordinates the care for an allocated number of residents. Health care assistants who provided direct care fedback to the nursing staff and entered in the residents' daily notes which were considered when determining if the care plan is implemented and effective or otherwise.

The care planning documentation did not contain a comprehensive communication plan which described residents' non-verbal communication mode if the resident did not have

verbal communication skills.

Residents had a choice of general practitioner (GP) and there was evidence that contact was made with the resident's previous GP if residents were admitted from outside the local area and all medical records were passed on to the GP of choice. An out of hours GP service is also available to residents.

Residents had access to a variety of health and social care professionals including geriatrician, physiotherapy, dietetic, speech and language, dental, ophthalmology, audiology, podiatry services and psychiatric services.
However, inspectors noted that one of the resident did not have a seating assessment by the occupational therapist and the resident's feet were not supported for a prolonged period during the day.

Management and staff told inspectors that residents and their family members are supported and end of life care is provided in accordance with the residents and their families' wishes. These are outlined in an advance directive/end of life care plan. The resident's general practitioner and community palliative care services are available as required and provide a good support for the residential care staff team.

Wounds were appropriately assessed and managed. Inspectors saw that residents were referred to the tissue viability specialist services when required.

Inspectors saw that pressure relieving mattresses and specialist cushions were in place however, one of the residents who was the focus of the inspection and who was identified as being at risk to developing pressure ulcers remained sitting in a wheelchair for the majority of the day without being repositioned.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Nutritional care plans were in place that detailed residents' individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. Nutritional and fluid intake records, when required were appropriately maintained. Inspectors found that residents with diabetes were appropriately managed.

Inspectors saw that the lunch meal was served to meet a variety of needs of residents for example those who were on a weight reduction diet, diabetic, fortified diets and modified consistency foods including thickened fluids.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised, medications reviewed and care plans were updated to include interventions to mitigate the risk of further falls.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents which were implemented for the residents who were the focus of the inspection. A pharmacist reviews each resident's drug kardex and

these findings are shared with the resident's GP who in turn reviews the resident's medication and make changes as appropriate. The GP was carrying out a review on the day of the inspection.

The inspectors observed the administration of medication at 17:00 hours. This was carried out satisfactorily with the exception that the staff nurse pre signed the administration records prior to administering medicines and had not sufficient preparation made to administer medicines to a resident who required a thickened drink to swallow the medicines.
Inspectors saw that prescribed creams and medication were not stored appropriately and in a secure place.

**Judgment:**
Non Compliant - Moderate

***Outcome 02: Safeguarding and Safety***

**Theme:**
Safe care and support

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

**Findings:**
The matters from the previous inspection related to the policy on safeguarding and the management of restraint. Inspectors found that the policy/procedure had not been revised to reference the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2014). Inspectors found that a restraint free environment was promoted as outlined below.

Some relatives communicated that they were aware of the role of the person in charge and staff nurse in charge and would have no hesitation in bringing any matter of concern to their attention.

Inspectors examined records relating to a previous internal investigation carried out by the provider and found that the allegation was appropriately managed and the safety of residents protected. There was evidence of learning from the investigation.

Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. An examination of the training records identified that not all staff had participated in bi-annual training in the protection of residents from abuse.

There was a policy and procedures in place that promotes a positive approach to the behaviours and psychological symptoms of dementia (BPSD) for example it emphasises

"non-restrictive and non-pharmacological interventions is the preferred method of providing support".

Inspectors found that staff had not participated in training regarding understanding and managing behaviour. Staffs' perception of challenging behaviour was not consistent for example in some instances it was clear that the behaviour was challenging, however, in other instances staff did not see the behaviours to be challenging even though this was confirmed by the validated assessment tool. Consequently staff had not implemented a care plan for residents with a challenging behaviour following assessment of residents using a validated assessment tool for residents with a cognitive impairment. This includes a seven-point rating Scale for assessing the frequency with which residents show certain behaviours.

A restraint free environment was fully promoted. At the time of completing the self-assessment questionnaire, restraint had been reduced to 14%. This was brought about by trialing enabler bars to assist residents to move in bed as opposed to using bedrails. A monthly audit was carried out in respect of restraint and a reduction had been noted month by month since 2014. In addition there were low-low beds and crash mats.

On the day of the inspection in the main, all of the residents were up and about during the day and a lap belt was used for one of the residents who was in a wheelchair. Only 4 residents were using bedrails and of the 4 residents, two residents had a bedrail on one side. Staff had risk assessed the alternatives.

Incidents where restraint was used were notified to the Authority in accordance with the regulation.

The inspectors reviewed the system in place to manage residents' money, and found that it was sufficiently comprehensive to ensure transparency and security. Residents' financial transaction records were signed and witnessed by two staff or a staff member and the resident. An examination of a resident's monies corresponded with the resident's financial records.
Residents had a locked facility in their own bedrooms to secure their processions and valuables.

**Judgment:**
Non Compliant - Moderate

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

**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:**
The action from the previous inspection related to inadequate arrangements for meaningful engagement with residents. This was not fully addressed.

Staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy and residents were supported to make choices and be independent. Inspectors saw some residents freely move around the centre choosing to participate in the group activities and going to their own rooms.

Inspectors observed that staff knew residents well and interacted with residents in an appropriate and respectful manner. Staff were observed knocking on bedroom and bathroom doors, and privacy locks were in place on bedroom, bathroom and toilet doors.

Inspectors were informed that staff sought the permission of residents before undertaking any care task however inspectors saw that communal toiletries were being used in the bathroom.

There was limited evidence that residents with dementia were involved in the consultation process with regard to the organisation of the centre. Management tried to establish a residents' forum and although 6 residents agreed that this would be beneficial only one resident attended the scheduled meeting. The last survey of residents' views and opinions occurred in 2014.

Residents were able to receive visitors in private either in their own bedrooms or in the designated visitor's room or in the alcoves located off the corridor. Residents' dignity was compromised in that personal items of a clinical nature were on display on the top of a wardrobe and personal information was on display in a twin bedroom. There were no restrictions on visitors and there were a number of areas where residents could meet visitors in private. A visitor's sign in book was available in a prominent location at the front entrance.

Residents were facilitated to exercise their civil, political and religious rights. Arrangements were in place for residents to vote and local politicians were in the centre talking to residents. This created great excitement for the residents as politicians were local to the area.

There was a variety of activities available to residents in the centre, organised by the activities staff and health care assistants. Residents' wishes and preferences informed their daily routines. Residents were satisfied with opportunities for religious practices.

The activity schedule advertised group activities arranged for the mornings and afternoons and individual sessions were scheduled for residents with more severe dementia or cognitive impairment who could not participate in the group activities.

Activities included music, board games, arts and crafts, gardening, exercise to music, reading, reminiscence, poetry, watching television and hand massages. Inspectors saw

mealtimes in the dining rooms were social occasions with attractive table settings and staff sat with residents while providing encouragement or assistance with the meal. The inspectors saw that some residents had a life story book which had been compiled by family and staff and the person in charge communicated to the inspectors the immense value this was to the resident. However inspectors noted that all residents had not been engaged in this activity.

In the main, staff were careful to ensure that residents with dementia were orientated to date and time, however, a resident had on display a calendar (not in the current year) which was displayed in a prominent position in the resident's bedroom. Inspectors were informed that the calendar was made up from family photographs, however, consideration had not been given to using this in another way such as a collage or life storybook.

Inspectors noted that in two of the twin rooms residents would have difficulty viewing the television because of its location in the room.

Family and staff members supported residents to maintain contacts with their community, for example some families took the residents to their homes to meet up with their relatives and neighbours. Residents with dementia had free access to a secure well maintained courtyard garden.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record at five minute intervals, the quality of interactions between staff and residents in the communal sitting room.

The definition of the scoring for the quality of interactions for the period observed is as follows: –
• +2 positive connective care – the facilitation of meaningful interaction and engagement with residents.
• +1 task orientated care – the provision of kind physical care, whereby interactions/conversation is more instructive.
• 0 neutral care – the delivery of services is passive and not stimulating.
• -1 protective and controlling – provision of individual care with the emphasis on safety and risk aversion.
• -2 institutional care – regarding residents as a homogeneous group who will fit into the established routine of the designated centre/home.

The scores reflect the effect of the interactions between staff and residents for the majority of residents.

The findings are as follows in respect of two distinctive observation periods in the afternoon during which there were organised activities: –
• For 66% of the two hour period, residents experienced positive connective care as staff interacted and engaged the majority of the residents
• For 15% of the observation period ,residents experienced positive interactions in respect of task oriented care.
• 19% of the time, the resident experienced neutral care.

However, inspectors observed that two residents with dementia who were case tracked experienced neutral care. Interaction with staff was limited and these residents were not assisted to participate in the organised activities. One resident had a sensory impairment.

**Judgment:**
Non Compliant - Moderate

***Outcome 04: Complaints procedures***

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

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

**Findings:**
There was a system in place to ensure that the complaints of residents with dementia or their representative were listened to and acted upon, and they had access to an appeals procedure.

There was a complaints policy and procedure. This detailed the process. The information was publicised throughout the designated centre and a summary was available in the resident's guide.

In addition to the designated complaints officer there was a designated person who would review the complaint and investigation process should a complainant be dissatisfied with the outcome.

Inspectors were informed that the activity therapist is the person who advocates for residents with dementia. The independent advocacy service was advertised, however, none of the residents availed of this service.

Residents who communicated with the inspectors were familiar with the staff and the person in charge. They communicated that if they had a difficulty they would approach any of the staff team. Relatives were satisfied that issues raised were addressed.

There was a complaints log which recorded the complaints, investigation of the complaint and the outcome for the complainant. Inspectors were satisfied with the records.

**Judgment:**
Compliant

***Outcome 05: Suitable Staffing***

**Theme:**
Workforce

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

**Findings:**
The recruitment procedures in place were satisfactory. This process included induction and probationary periods for staff. Three new staff were participating in orientation/induction during the inspection period.

An examination of randomly selected documentation in relation to staff working in the designated centre found that not all of the information identified in schedule 2 was available for example Garda vetting.

Inspectors found that there were appropriate staff numbers and skill mix to meet the assessed needs of residents.

There was a planned staff roster in place, with changes clearly indicated. The staffing in place on the day of inspection was reflected in the roster.

There were a variety of meetings scheduled in order to ensure that staff of various grades had appropriate knowledge to deliver services to residents. This included handover meetings at the change of shifts and performance management meetings.

Inspectors found that while there were opportunities for staff to participate in education and training relevant to their role and responsibility some staff had not completed necessary training or required refresher training for example training in moving and handling, dementia training and fire safety training.

The staffing arrangements provided for the supervision of residents in communal rooms and staff who communicated with the inspectors were knowledgeable of residents' conditions and preferences.

**Judgment:**
Non Compliant - Moderate

***Outcome 06: Safe and Suitable Premises***

**Theme:**
Effective care and support

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

No actions were required from the previous inspection.

**Findings:**
The design and layout of the centre was suitable for its stated purpose and met residents individual and collective needs in a comfortable and homely way.

It is a purpose-built single floor building with a spacious entrance. Residents' bedrooms are ensuite. Primarily the bedrooms are for single use, however there are 8 twin rooms. Inspectors found that the resident's bedrooms were equipped with modern and bright furnishings including televisions, telephone points and a resident alarm system. Bedrooms were personalised and residents with dementia knew their rooms as they walked around the centre. Residents had a view of the surrounding countryside from their own bedrooms and some residents preferred this to the communal sitting area.

There was ample communal dining and sitting room facilities for residents. A quiet room located within the main communal sitting room was used more for storage and was not welcoming as a tranquil environment for residents.

The designated centre was built around a courtyard which provided a safe external area for residents to walk and sit outside.

There were signs on the bathrooms and toilets and bathroom doors were a different colour to the surrounding wall. Call/alarm buttons in the bedrooms, toilets, bathrooms were visible and well-positioned. The assisted bathroom required refurbishment including reflooring and redecoration. This was on the maintenance scheduled for 2016.

The environment assists residents with mobility difficulties as there are long corridors which are suitable for residents using wheelchairs and for residents walking to maintain their independence. In this respect there were grab rails and hand rails. The alcoves located off the corridor provided a resting place for residents during their walks. However, it was difficult to distinguish one corridor from another as there was no contrast in wall colours at the end of each corridor, no stimulating decorations on the walls and limited signage. The floor coverings were nonslip and consistent in colour.

Inspectors noted that it was cold in one particular corridor and were informed that there is no heating in the corridors only in the alcoves. There were no thermometers to gauge the temperature. This matter had been previously been raised in a complaint and at that time had been resolved by management increasing the temperature of the overall centre.

There was evidence of the availability of equipment to meet residents needs and systems were in place to monitor this equipment for example servicing of a variety of hoists and profile beds.

**Judgment:**
Substantially Compliant

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

**Theme:**
Safe care and support

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

**Findings:**
The matter arising from the previous inspection related to risk policy not being implemented in respect of residents who smoke in the centre. This matter had been reviewed, however, at the time of the inspection there were no residents smoking.

Inspectors found that staff had not practised a simulated drill for the implementation of the policy in respect of an unexplained absence of any resident.

**Judgment:**
Non Compliant - Moderate

## *Outcome 08: Governance and Management*

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was no 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 the relevant standards set by the Authority.

**Judgment:**
Non Compliant - Major

## 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:***

Siobhan Kennedy
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**[1]

| | |
|---|---|
| **Centre name:** | Eliza Lodge Nursing Home |
| **Centre ID:** | OSV-0000663 |
| **Date of inspection:** | 16/02/2016 |
| **Date of response:** | 16/03/2016 |

## Requirements

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

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

## Outcome 01: Health and Social Care Needs

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans were not sufficiently comprehensive as they did not assess and describe the care to be implemented to address the residents' social, emotional and psychological needs.

**1. Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

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:**
On review of our Residents Care Plans, we endeavour to:
• Ensure that at all times care plans are discussed and developed with the resident and where appropriate their family and multi-disciplinary team.
• Ensure that Care Plans assist Residents to maintain their sense of identity. We will include the Resident as much as possible in decision making to help them maintain their functional abilities and independence for as long as possible.
• We will ensure that our current communication Care Plan is expanded to incorporate non-verbal communication/cues for all residents. We will also ensure that the Care Plans thoroughly meet the residents social, emotional and psychological needs.
• Care Plans will be reviewed within 4 months or earlier as required.

**Proposed Timescale:** 30/05/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Pre-assessment documentation was not available for inspection.

**2. 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:**
Residents admitted to Eliza Lodge are pre-assessed by the Director of Nursing to ensure that we can meet and provide the service required by the resident. We will expand this assessment to ensure that it fully meets the personal and social care needs of the Resident.

**Proposed Timescale:** 11/03/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans had not been devised following the adoption of a validated assessment tool for assessing residents with a cognitive impairment.

The care planning documentation did not contain a comprehensive communication plan which described residents' non-verbal communication mode if the resident did not have verbal communication skills.

**3. 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:**
As per above, we will ensure that our current communication Care Plan is expanded to incorporate non-verbal communication/cues for all residents. We will also ensure that the Care Plans thoroughly meet the residents social, emotional and psychological needs.

**Proposed Timescale:** 30/05/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
A resident did not have a seating assessment.

**4. Action Required:**
Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

**Please state the actions you have taken or are planning to take:**
The resident was due to be assessed by an external consultant on the 9th of March 2016. Unfortunately the external consultant did not visit Eliza Lodge due to sickness. The dates we have been provided with for the next consultation is 30th March 2016 or the 12th April 2016.
In the meantime, the resident has been assessed by our nursing staff and is sitting on a Coquelicot Chair which is designed for residents with reduced mobility. The chair is advertised as "providing unrivalled levels of comfort and care for the user". The chair also had a pressure relieving cushion fitted.

**Proposed Timescale:** 12/04/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A resident who was the focus of the inspection and who was identified as being at risk of developing pressure ulcers remained sitting in a wheelchair during the afternoon and

part of the evening without being repositioned.

**5. 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:**
With regard to the resident in question, monthly assessments are carried out to protect the resident from the risk of pressure ulcers. The following protective measures in place for this residents are:
• Monthly audit of Residents Weight, BMI and Waterlow.
• Based on findings, this resident was placed on a pressure relieving mattress and cushion.
• Resident has been regularly reviewed by dietician with appropriate supplement prescribed.
• The "wheelchair" that the residents sits in is a Coquelicot Chair which is designed for residents with reduced mobility. The chair is advertised as "providing unrivalled levels of comfort and care for the user". The chair also had a pressure relieving cushion fitted. This armchair is not a standard transient wheelchair.
• The resident's pressure areas are fully intact and has since been reviewed by a Tissue Viability Nurse who has made no changes to current arrangements.

We acknowledge and regret that on the day of our inspection that the resident did not have their pressures relieved/repositioned as required.
We are aware of our responsibilities in accordance with professional guidelines issued by An Bord Altanais. We have recommunicated this responsibility to all staff and will ensure that there is full compliance with regard to this matter.

**Proposed Timescale:** 11/05/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Prescribed creams and medication were not stored appropriately and in a secure place.

**6. Action Required:**
Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

**Please state the actions you have taken or are planning to take:**
The creams and medication which were not stored appropriately were Emulsifying creams and Cavilon cream. These creams are now stored appropriately and individually labelled.

**Proposed Timescale:** 11/03/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Administration of medicines was not carried out in accordance with the designated centre's policies and procedures as the staff nurse pre-signed the administration records prior to administering medicines to residents.

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

**Please state the actions you have taken or are planning to take:**
We have communicated with our Staff Nurses with regard to medication management and the importance of full compliance with regulation and our policy. Staff Nurses have also been reminded of the importance of being fully prepared and organised to meet the needs of the individual resident (i.e. preparation of thickened fluids if required) prior to drug administration. Our Staff Nurses are now in full compliance with the administration of medication, only signing for medications when they have been fully administered. We will continue to monitor all aspects of medication management to ensure ongoing compliance.

**Proposed Timescale:** 11/03/2016

**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The policy/procedure in place for the prevention, detection and response to abuse had not been updated to reference the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2015).

**8. 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:**

Our policy for the detection and prevention of abuse has been fully revised as of 21st of August 2015 in line with National Policy 'Safeguarding Vulnerable Persons at risk of Abuse'(2015).
A copy of this policy has previously been forwarded to HIQA and has been attached.

**Proposed Timescale:** 11/03/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff had not participated in training to update their knowledge and skills appropriate to their role to respond to and manage behaviour that is challenging.

**9. 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:**
We have dementia training scheduled for 29th March, 4th & 5th of April and also on 14th, 20th and 21st June 2016. This 3 day course focused on Enhancing and Enabling Well-Being for the Person with Dementia and Dealing with Responsive Behaviours and Supporting and Understanding the Person with Dementia.
We will place as many staff as possible on these courses.

**Proposed Timescale:** 21/06/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
All staff had not participated in bi annual training in the protection of residents from abuse.

**10. 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:**
We have an in-house Elder Abuse Trainer. We will ensure that all staff receive the necessary bi-annual training.
Since our inspection, all Staff Nurses have received training in Safeguarding Vulnerable Persons from Abuse. This training took place on 14th March 2016.

**Proposed Timescale:** 30/04/2016

**Outcome 03: 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:**
Two residents with dementia did not have opportunities to participate in activities in accordance with their interests and capacities.

**11. 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:**
In Eliza Lodge we endeavour to provide activities based on residents likes, interests and needs. All residents are involved as far as possible or as far as they wish. Our Activities Coordinator is supported by Care Staff to enhance daily activities. Where there was an activity which did not suit two residents or meet the needs of two residents, alternative activity/stimulation should have been provided.
We have communicated this to our Activity Coordinator and to all staff and will actively review the same.

**Proposed Timescale:** 11/03/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The systems in place did not fully support residents with dementia to participate in the organisation of the designated centre.

**12. Action Required:**
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

**Please state the actions you have taken or are planning to take:**
We conducted a questionnaire with residents in September 2015, the purpose of which was to ascertain that all residents feel safe in Eliza Lodge and to actively seek residents opinion on any other matter with regard to life in Eliza Lodge. For the resident who could not verbally communicate or respond to this questionnaire we conducted the same with the residents family member.
We will consult with all residents with regard to the organisation of the centre and will incorporate their views into day to day life in Eliza Lodge.

**Proposed Timescale:** 30/06/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
In two of the twin rooms the television facility was not located in a position that could be viewed by the two residents.

**13. Action Required:**
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

**Please state the actions you have taken or are planning to take:**
Due to the design of the two rooms it is impossible to place a television in a location where both residents can view the screen from their beds. Seating can be arranged to accommodate both residents viewing the screens.

**Proposed Timescale:** 11/03/2016

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All staff did not have access to appropriate training for example training in moving and handling, dementia training and fire safety training.

**14. 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:**
Moving and Handling Training has taken place on 3rd March 2016 for staff who required refresher training and for all new staff.
Dementia Training. In consultation with Psychiatry of Later Life we have secured the following dates for dementia training (3 day course) March 29th, April 4th and April 5th and again on June 14th, 20th and 21st. We will place as many staff as possible on these courses.
Fire Training will be completed by 30th April 2016 for new staff and staff who require refresher training. In the meantime we will continue to conduct routine drills.

**Proposed Timescale:** 30/06/2016

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Documentation in relation to staff working in the designated centre was not in accordance with schedule 2 of the regulations.

**15. 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:**
We are awaiting the return of Garda Vetting Forms for new staff. In the meantime, all new staff have been required to sign a self-declaration form confirming that there are no criminal convictions against them.

Proposed Timescale: Awaiting return of Vetting forms from An Garda Siochana.

**Proposed Timescale:**

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was insufficient heating in the corridors.

The designated centre was not laid out to meet the needs of residents with dementia as follows:

It was difficult to distinguish one corridor from another as there was no contrast in wall colours at the end of each corridor.

There was limited stimulating decorations on the walls of the corridor and limited signage.

A quiet room was primarily used for storage.

**16. 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:**
• We have fitted thermometers in the corridors to track temperatures.
• We will look at distinguishing each corridor by colour. We have met with a Painter and Decorator with regard to colour schemes.
• We will consult with Residents and Family members in relation to decoration/signage of the Residents Bedroom Doors.
• We will redesign the layout of the quite room.

**Proposed Timescale:** 31/07/2016

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

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff had not practised a simulated drill for the implementation of the policy in respect of an unexplained absence of any resident.

**17. Action Required:**
Under Regulation 26(1)(c)(ii) 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 unexplained absence of any resident.

**Please state the actions you have taken or are planning to take:**
We have developed a comprehensive guide in respect of an unexplained absence of any resident. We have carried out a drill on 15th March 2016 using this guide and will conduct further drills in the coming weeks.

**Proposed Timescale:** 11/03/2016

**Outcome 08: Governance and Management**

**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 of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with the relevant standards set by the Authority.

**18. 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:**
We carry out audits are regular intervals with regard to different aspects of the service we provide to ensure efficiency, quality and safety of the care provided. We are currently designing an audit to pull this information together as well as capturing additional information into all aspects of care provided in Eliza Lodge.
This review will be completed on an annual basis.

**Proposed Timescale:** 31/07/2016