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:	Blainroe Lodge
Centre ID:	OSV-0000016
Centre address:	Coast Road, Blainroe, Wicklow.
Telephone number:	0404 60030
Email address:	blainroe@firstcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Firstcare Ireland (Blainroe) Limited
Provider Nominee:	John O'Donnell
Lead inspector:	Leone Ewings
Support inspector(s):	Jim Kee
Type of inspection	Unannounced
Number of residents on the date of inspection:	67
Number of vacancies on the date of inspection:	3

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 monitor ongoing regulatory compliance. 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:
05 January 2016 10:30	05 January 2016 19:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an unannounced monitoring inspection by the Health Information and Quality Authority (the Authority). The purpose of the inspection was to monitor ongoing compliance with the Care and Welfare Regulations and the National Standards. It also followed up on matters arising from the registration renewal inspection carried out on 24 March 2014, and to monitor progress on the four major non-compliances found at this time. A satisfactory action plan update was submitted following a request from the Authority on 6 May 2015.

This inspection also considered information received by the Authority relating to health and social care needs and complaints management. There was no evidence to substantiate this information. However, improvements relating to staff supervision and training were required.

As part of the inspection, the inspectors met with residents, relatives and staff

members, observed practices and reviewed documentation such as policies and procedures, care plans, medical records and risk management processes.

The inspectors found that some improvements had taken place since the last inspection. Staff were observed to be responsive to residents' needs. Overall, inspectors found that residents expressed satisfaction with care and supports available to them to the inspection team.

A total of 11 Outcomes were inspected and three outcomes were in full compliance. One outcome - Complaints was substantially compliant. Moderate non compliance was found relating to:

- Governance and management
- Medication
- Records
- Safeguarding
- Health and safety and risk management
- Staffing

The action plan at the end of this report identifies these and other areas where improvements must be made to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. Twelve actions are the responsibility of the registered provider to address, and two actions are the responsibility of the person in charge.

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

Findings:
Overall, whilst there were some improvements since the time of the last inspection. Further improvements were required to address the non-compliances found at this inspection. Particularly relating to the effective governance of the centre.
A report on the quality and safety of care for resident for 2014 was reviewed and addressed the non-compliance further to the last inspection. A quality improvement plan was for 2015 was also included. Positive changes had taken place since this time. For example, the household cleaning was now contracted in and managed by a household manager on site. However, the standard of hygiene required review and improvement. A report on quality and safety of care outcomes was planned for 2015.

Inspectors reviewed the monthly operations report for December 2015 that included information and review in a number of key areas including human resources, notifications, audits, accidents and incidents, dependencies, complaints and concerns, facilities and maintenance, activities and staff training. This report also referenced monthly audits that were conducted within the centre that included audits of accidents and incidents, tissue viability, care plans, fire, call bell response, pressure relieving mattresses, health and safety, medication management and restraint. However, a detailed staffing review had not been conducted to evaluate staffing resources meeting assessed care needs.

The inspectors reviewed the last medication management audit conducted by the pharmacist, and one of the findings had been that some PRN (as required) medicines were not in stock. There was no indication on this audit to indicate that management within the centre had implemented an action plan to address this issue. Similarly the most recent audit of restraint in the centre did not identify and include any plans to review restrictive practices with a view to reducing the use of restrictive practices such as bed rails were possible.

Judgment:
Non Compliant - Moderate

Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
Improvements were noted since the time of the last inspection relating to the inclusion of details of additional charges included in the contracts of care. The inspector reviewed contracts of care in place and was satisfied that the provider had addressed this moderate non-compliance. Written details of the additional service charges (ASC) levied were clearly outlined in the schedule of information with each contract. The administrator outlined to the inspector that if there are any queries she can provide additional information, or the financial controller can be contacted directly for any clarification around finances.

Judgment:
Compliant

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

Findings:
The centre was managed full time by a registered and experienced nurse, who had been in post for almost two years. A satisfactory assessment of fitness took place at the time of the last inspection. The person in charge who was also known as the director of nursing was familiar with the requirements of Regulations and her responsibilities.

The person in charge managed the centre with authority and accountability, inspectors saw she was present in the centre and was familiar with the residents and their social and health care needs. She was supported by a clinical nurse manager on a day to day basis. She reports to the operations manager and has regular minuted meetings. A further clinical nurse manager was being recruited at the time of the inspection.

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

Findings:
Inspectors found that some improvements had taken place to maintain complete and accurate residents' records in line with regulatory requirements. For example, residents weights were now found to be documented accurately, and details of the implementation of care was now fully documented. However, the findings of this inspection confirmed that further improvements were required with regard to care plans, records of medication management, and specific behavioural support plans for residents with challenging behaviours.

The centre had all of the written operational policies as required by Schedule 5 of the Regulations and in sufficient detail as to guide staff. The records listed in Part 6 of the Regulations in the main were maintained in a manner so as to ensure completeness, accuracy and ease of retrieval using an electronic record keeping system.

Improvements were required in relation to medication records as detailed in Schedule 3 of the Regulations. The policies and procedures relating to medicines required by Schedule 5 were not always appropriately implemented;

-The inspectors noted that the temperature of the medication storage fridge had been outside the recommended temperature range on a number of occasions in December 2015, which indicated that appropriate measures were not in place to ensure medicines that required refrigeration were stored at the recommended temperature with measures

in place to respond to fridge temperatures outside 2-8 degrees Celsius. The inspectors also noted that one nutritional supplement that required refrigeration once opened was not being stored in the fridge and was being stored in the medication trolley.
-The allergy section of the prescription sheet was not completed for all residents to ensure that it was clear if residents had any known allergies to medicines or if there were no known drug allergies (NKDA).
-One resident's medicine administration record sheet contained blank spaces with no documented explanation as to why the medicines had not been administered as prescribed.

Judgment:
Non Compliant - Moderate

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

Findings:
Improvements had taken place as a result of the last inspection. Measures were put in place to supervise all residents and ensure that any residents with wandering behaviours which may adversely impact another resident were managed. Records of training received by staff in responding to challenging behaviours were reviewed and had taken place in 2014, 2015 and were planned for 2016.

Measures to protect and safeguard residents were in place on this inspection and the nursing supervision as outlined in Outcome 18 of this report required further improvement. The findings of this inspection confirmed that further improvements were necessary. The Authority had been notified of two separate allegations of abuse. Both incidents had been fully investigated and actioned by the provider in line with the safeguarding policy in a timely manner, and all residents fully safeguarded. The person in charge confirmed that a family meeting was planned to provide support as a result of this adverse finding for later that week.

The records of staff training were reviewed and confirmed that staff had received training on identifying and responding to elder abuse. Inspectors spoke with staff who with were aware of the types of elder abuse, the potential indicators of abuse and the procedure to follow if there was any suspicion or allegation of abuse. There was a policy

in place to guide staff and there were records indicating that staff training had taken place and was up to date. Further staff training was taking place on the day of the inspection in safeguarding. An external trainer had also been sourced to provide additional training, as a result of feedback from the internal investigation report.

Inspectors found that there were high numbers of bed rails reported as in use at the centre. The use of chemical restraint was also notified to the Authority. The person in charge confirmed that work was being implemented to move towards a restraint free environment. The inspector reviewed a sample of relevant records and found that the records did not confirm in all cases where alternatives had been trialled and used in line with best practice. As outlined in Outcome 9 - Medication the indicators for using any form of prescribed psychotropic medication required review. For example, following a review of the documentation the inspectors found that appropriate positive behavioural care plans were not consistently in place for the protection of all residents. While there was a risk assessment around inappropriate behaviours relating to a small number of residents, the care plans required improvement in order to inform all staff on how to manage any challenging behaviours and offer appropriate care for residents. The inspectors saw training records which confirmed that training had taken place for staff in challenging behaviours. All except one of the nursing staff and the majority of care staff had received this training since the last inspection. However, some improvements specific to assessing, planning and documenting care were still required.

Judgment:
Non Compliant - Moderate

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:
A detailed risk management policy was in place and a risk register. However, the inspectors observed six of the resident's self-closing bedroom doors wedged or held open on the ground floor. The risks associated with this practice were discussed with staff on duty and the person in charge. The practice ceased on the day of the inspection. The operations manager informed the inspectors that guidance would be sought with regard to provision of devices which would allow for residents to keep their doors open if they chose to do so, and operated on response to the fire alarm.

The staff training records relating to fire safety were confirmed following a review of mandatory training records. Emergency lighting, alarm and fire fighting equipment were in place and maintained in all parts of the designated centre. Staff who spoke with

inspectors on the day of the inspection were clear on the actions to take in the event of fire.

The risk of cross infection with blood glucose monitoring required review as inspectors noted that the centre was using one lancing device suitable for single patient use on multiple residents with a new lancet needle for each resident. The management were informed that each resident required their own individually labelled lancing device or single use safety lancets were to be used.

The communal areas and bedrooms were generally found to be clean, a number of corridors, on all floors and exit doors had visible cobwebs and dust was apparent. The standard of general hygiene at the centre required improvement. The sluice room was being used interchangeably as a cleaner's room on the first floor, and inspectors requested that this area have a deep clean on the day of the inspection as the standard of hygiene was inadequate. This was satisfactorily completed. The person in charge was asked to review the risks associated with infection prevention and control in the dual use of this room.

Staff had attended moving and handling training provided by an external physiotherapy provider. Inspectors observed adequate practice relating to moving and handling, and residents had access to assistive equipment. However, a number of the communal areas were cluttered with objects, extra cupboards and handling belts, which restricted the access of those residents who used hand rails to mobilise.

The risks associated with the storage of oxygen cylinders required review. Cylinders were stored and available on all floors. However, five cylinders were found in a locked storeroom internally in the building which was not in line with good practice.

Judgment:
Non Compliant - Moderate

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

Findings:
The inspectors reviewed the practices and documentation in place relating to medication management in the centre. Two of the actions required following the last inspection in the centre to address identified non compliances had not been fully addressed. Inspectors found that a number of prescription sheets did not specify times of

administration. This had been previously identified as a non compliance in March 2014. The information available to staff on prescription sheets and in care plans regarding the administration of PRN (as required) medicines was not sufficient to ensure safe consistent administration practice by staff. This issue had been previously identified as a non compliance in March 2014. The inspectors were informed that the planned implementation of an electronic medication management system, that had been included in the action plan response to the last inspection had been postponed due to a change in nursing staff and a number of new nurses commencing work in the centre. The management of the centre informed the inspectors that the implementation of this system was now planned for early 2016.

The centre had operational policies relating to the ordering, prescribing, storage and administration of medicines. Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system and were appropriate. Residents were facilitated to have their medicines dispensed by their pharmacist of choice. All medicines were stored securely within the centre, and a fridge was available for all medicines or prescribed nutritional supplements that required refrigeration, and the temperature of this fridge was monitored. However the temperature of this fridge had been outside the recommended temperature range on a number of occasions in December 2015. This indicated that appropriate measures were not in place to ensure medicines that required refrigeration were stored at the recommended temperature with measures in place to respond to fridge temperatures outside 2-8 degrees Celsius. This finding is included under Outcome 5. The inspectors also noted that one nutritional supplement that required refrigeration once opened was not being stored in the fridge and was being stored in the medication trolley. This finding is included under Outcome 5. All controlled (MDA) medicines were stored in a secure cabinet, and a register of these medicines was maintained with the stock balances checked and signed by two nurses at the end of each working shift.

The inspectors reviewed the processes in place for administration of medicines, and were satisfied that nurses were knowledgeable regarding residents' individual medication requirements and followed professional guidelines. Nursing staff were observed to safely administer medicines. There were procedures in place for the handling and disposal of unused and out of date medicines.

The inspectors reviewed a number of the prescription and administration sheets and identified a number of issues that did not conform with appropriate medication management practice:
- A number of residents required their medicines to be crushed prior to administration and this was documented at the top of the prescription sheet. The prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
-The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines and in some cases the times of administration were not clearly indicated (the prescription did not consistently indicate if the medicine was to be administered once daily or twice daily or the times at which medicines were to be administered)
-The indication for use of PRN (as required) medicines was not consistently documented on the prescription sheet and there were no associated resident specific care plans in

place for these medicines to guide staff in the administration of these medicines (in some cases residents had been prescribed more than one psychotropic medicine on a PRN basis but the prescription did not indicate when the medicines were to be used or which medicine was to administered first. There were no protocols in place as part of behaviour support plans or care plans to guide practice to ensure appropriate consistent administration)
-The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet. In some cases the dose and route of administration were not clear and there was no further information available in care plans to guide staff.
-The allergy section of the prescription sheet was not completed for all residents to ensure that it was clear if residents had any known allergies to medicines or if there were no known drug allergies (NKDA).(This finding is included under Outcome 5)
-One resident's medicine administration record sheet contained blank spaces with no documented explanation as to why the medicine had not been administered as prescribed. (This finding is included under Outcome 5)

The pharmacist was facilitated to meet all necessary obligations to residents in accordance with guidance issued by the Pharmaceutical Society of Ireland, and visited the centre on a regular basis, conducting reviews of residents' medications and medication audits. One of the inspectors was shown the last audit conducted, and one of the findings had been that some PRN (as required) medicines were not in stock. There was no indication on this audit to indicate that management within the centre had implemented an action plan to address this issue. This finding is included under Outcome 2.

There were systems in place within the centre for reviewing and monitoring medication management practices, including medication management audits conducted by the clinical nurse manager that reviewed the prescribing, administration records and storage of medicines within the centre. Medication incidents including medication errors were recorded and reviewed within the centre.

Judgment:
Non Compliant - Moderate

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):

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

Findings:
Overall the inspectors found that some improvements had taken place since the time of the last inspection to address the major non-compliance relating to inconsistency of care and records. However, as outlined in Outcome 5 of this report further work is required to meet the Schedule 3 requirements of the Regulations. Each residents' wellbeing and welfare was maintained to a good standard of evidence based nursing care and appropriate medical and allied healthcare. Social care provision had improved and all residents (or their representative) were involved with the care planning process.

Judgment:
Compliant

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:
The complaints procedure was seen to be on display at the main entrance to the centre and each resident received information on how to make a complaint on their admission to the centre. The written policy on complaint's management was in line with legislative requirements.

A record of both written and verbal complaints, was maintained and that complaints were being dealt in a timely manner by the person in charge. Each complaint listed the details of the complaint, and the communication and investigation which took place. The inspector found that two written complaints were received by the centre and these were managed in line with the policy. There was an up to date complaints policy which listed a nominated complaints officer within the centre and an independent officer was available for appeals. There was some evidence of service improvement as a result of feedback about staffing, where additional staffing had been put in place following a complaint about supervision of staff at night.

The complaints records also stated that the complainant was informed of the outcome of each complaint, however, this could not be fully evidenced in the records on one occasions. Details of the appeals process was not communicated as required by legislation.

Judgment:

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

Findings:
The non-compliances relating to the policy and use of CCTV had been addressed by the provider. Staff were observed interacting in a respectful and meaningful way throughout the inspection. Non person centred practices were not observed at any the time of this inspection.

Judgment:
Compliant

Outcome 18: Suitable Staffing
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:
Workforce

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

Findings:
Some improvements had taken place since the time of the last inspection. Residents and relatives expressed satisfaction with staff at the centre. A staff handover at 12 midday

was observed by one of the inspectors and was informative and clear communication was demonstrated in the team. All staff were aware of their fire safety procedures, safeguarding policy and residents' moving and handling requirements. Mandatory training was up to date for all staff and training in recognising and responding to challenging behaviours had been completed further to the last inspection.

A review of the current staffing rosters was completed by the inspectors, and discussed with the person in charge. No evidence of any written review of staffing (other than the management report) was given to inspectors to evidence as to how staffing had been reviewed since the last inspection. The action plan update received on 6 May 2015, stated that a staffing guidance tool was used by the person in charge and adjusted accordingly. this did not inform the most recent management report shown to the inspector. The person in charge confirmed that a recruitment programme was being actively implemented, and some staff had recently completed their induction programmes. The management report read by inspectors identified deficits in documentation, care planning and audits not fully completed for December 2015.

The person in charge and operations managed cited high staff turnover as being an issue in 2015, but this had now decreased. Inspectors found that there was evidence that staffing provision and requirements needed closer review, and analysis. For example, The inspectors were informed that two nurses were responsible for clinical care and supervision in four separate areas within the centre. Residents were accommodated in four smaller separate floors accessible by lift and stairs. On the day of the inspection four registered nurses were on duty in line with the planned roster. A additional staff nurse was also rostered and allocated to update care plans. This approach was not found to be fully consistent with individualised person centred care and requires review. The documentation as outlined in Outcome 5 of this report requires review and improvements required in medication management in Outcome 9. The two rostered staff nurses were largely allocated all nursing duties during the day supported by the person in charge or her deputy if required. At night two nurse and four care staff worked to meet residents assessed needs.

There had been a complaint to the person in charge relating to resident supervision during 2015 and this had been fully addressed by the person in charge. However, all aspects of clinical supervision and staffing had not been considered subsequent to this complaint. For example, the use of bed rails was high, and use of as required psychotropic medication could not be fully evidenced as a last resort as outlined in Outcome 9 of this report.

The dependencies of the 67 residents was reviewed and on the day of the inspection, half of the residents were assessed as being of maximum or high dependency. Some residents identified to inspectors had behavioural support plans in place, with additional supervision measures in place. While staff observed had provided adequate care on the day of the inspection the staffing levels. The inspectors found that the current staffing provision did not fully take into account the design and the layout of the premises. Residents were accommodated in four separate areas accessible by lift and stairs. Bed rail use had been identified and highlighted to the previous person in charge as an issue on previous inspection. Staff training in restraint/restrictive practices did not include the use of chemical restraints and further training was required in bed rail risk assessment.

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:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Blainroe Lodge
Centre ID:	OSV-0000016
Date of inspection:	05/01/2016
Date of response:	01/04/2016

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Management in the centre were conducting audits in a number of areas but in some cases there were no action plans put in place to address identified issues:
-One of the findings of the most recent medication management audit conducted by the pharmacist had been that some PRN (as required) medicines were not in stock. There was no indication on this audit to indicate that management within the centre had implemented an action plan to address this issue.

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

-An audit of restraint had been conducted in October 2015 but there was no associated plan in place to review restrictive practices with a view to reducing restrictive practices including the use of bed rails.

1. 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 monitored.

Please state the actions you have taken or are planning to take:
The medication audits conducted by the Pharmacy will contain an action plan sheet to document and provide evidence to support the recommendations of the audit (conducted by the pharmacy) have been carried out. Previously the actions/recommendations had been carried out but were not formally recorded. (Proposed Timescale - March 30th 2016)

The restraint audit will be reviewed to include a section for an action plan. Moving forward all restraint audits will be reviewed monthly by both the Home Manager and the Operations Team. In liaison with the residents and families post inspection, 5 bed rails have been decommissioned. (Proposed Timescale - April 30th 2016)

Trials to reduce the use of bedrails in the home have commenced, bearing in mind the resident's choice, preferences and wishes relating to the use of bedrails. As per our Annual Report our aim is to reduce the number of restraints used by 10% in the first half of 2016 and a further 10% in the second half of the year. (Proposed Timescale – Year End 2016)

Proposed Timescale: 31/12/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure requires review as currently improvements in accountability.

2. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
As outlined on the day of this inspection, the senior management team had previously identified the need for additional nursing management support in the Nursing Home. The advertisement of a second CNM post both internally and externally on 19th December had yielded several applicants for the post and interviews have taken place and the position offered and accepted. The new CNM commenced her new role on February 29th 2016.

The management structure supporting Blainroe Lodge has been changed. FirstCare now have a Managing Director, an Operations Manager, and a new Compliance Manager, supporting the Home Manager with the day to day running of her home.

The roles and responsibilities of the management team in Blainroe Lodge will be clearly outlined by the Operations Team, reviewed monthly and audited through performance appraisals.

Proposed Timescale: 31/03/2016

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:
The policy in place relating to the storage of medicines was not being appropriately implemented to ensure that medicines that required refrigeration were stored at the correct temperature at all times.
-one prescribed nutritional supplement that required refrigeration once opened was not being stored in the fridge.
-documented temperature checks on the fridge indicated that the temperature of the fridge had been outside the recommended temperature range of 2-8 degrees Celsius for a significant period of time.

3. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
All staff have been reminded of the policy relating to the safe storage and disposal of nutritional supplements. It was the intention of the Nurse on duty to dispose of the supplement post medication round as it was not due to be refrigerated.

The fridge was examined thoroughly by the Home Manager and this indicated that it was clean and had been defrosted. There was no evidence to indicate that the fridge was not functioning. A further review was conducted by the technician from the pharmacy who advised the fridge was fully functioning and there was nil to note in respect of the fridge.

A review of the environment/location of the medication room will be undertaken to determine if any external factors are contributing to the variances to the recommended temperature of the medication fridge/storage area. However, the technician that examined the fridge felt the variances were due to the fridge being opened prior to the temperature readings been taken and it requiring a period to re-regulate its temperature internally.

Proposed Timescale: 30/03/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records of medication administration were not being maintained in accordance with relevant professional guidelines as required under Schedule 3 (d) (h) (I) of the regulations in that;
-The allergy section of the prescription sheet was not completed for all residents to ensure that it was clear if residents had any known allergies to medicines or if there were no known drug allergies (NKDA).
-One resident's medicine administration record sheet contained blank spaces with no documented explanation as to why the medicines had not been administered as prescribed.

4. 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 specific care plans discussed on the day of inspection will be reviewed to ensure that they give clear, and specific guidelines to ensure staff are fully informed and guided on all aspects of care.

Proposed Timescale: 31/05/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Care plans in place did not contain enough details to fully guide and inform staff implementing care.

5. 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:
As discussed with the Inspector on the day of inspection, FirstCare are implementing a computerised medication management system. This will be implemented in the home prior to year end, and will alleviate the issues regarding the recording of allergies both

known and NKDA. (Proposed Timescale – Year end 2016)

All Nursing Staff have had additional training relating to the completion of the MARs sheet and the policy on recording of Medication has been reiterated at handovers by the Home Manager. (Proposed Timescale – Immediate post inspection)

All prescription sheets have been audited and those not displaying the information listed above have been amended. The appropriate legend for the documenting of why residents did not have specific medications administered, such as, declined by the Resident, or while a Resident is in hospital, has been laminated and is now available on all drug trolleys and medication storage rooms. (Proposed Timescale – Immediate post inspection)

The Compliance Manager will review the Medication Audit Tool to ensure it captures any omissions on the MARs moving forward. (Proposed Timescale - April 30th 2016)

Proposed Timescale: 31/12/2016

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:
Chemical and physical restraint and use of bed rails were not consistently used in line with best practice. Evidence of alternatives trialled before implementing were not evidenced.

6. 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:
Two further psychotropic medication training sessions have been completed post inspection. (Proposed Timescale – Completed February 11th)

Trials have commenced within the home to reduce the use of bedrails bearing in mind the resident's choice, wishes and preferences. In liaison with residents and families post inspection, a total of 5 bedrails have been decommissioned.

As per our Quality Improvement Report for 2016 we will endeavour to reduce the number of restraints used by 10% within the home in the first half of 2016, and a further 10% in the second half of the year. However, this is dependent on the support of residents and their families. (Proposed Timescale – December 31st 2016)

Proposed Timescale: 31/12/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Resident's relative had not been notified of an allegation of abuse.

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

Please state the actions you have taken or are planning to take:
As advised on the day of inspection the alleged abuse had come to light during another investigation in house. The appropriate notification form was completed and immediately sent to the Authority. A full investigation was initiated retrospectively into the incident by the Operations Team. Subsequent to the initial investigation ending, the family involved were informed fully of the details surrounding the incident. The family fully understood the circumstances around the incident and the necessary delay in reporting same to them. They were content and happy that their family member was safe and well cared for within the Nursing Home. The family were also reassured by the prompt process that had taken place when the management became aware of the incident and the eventual outcome of both investigations.

Proposed Timescale: 10/01/2016

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 number of physical hazards in the environment required review to mitigate risks associated with storage on corridors.

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

Please state the actions you have taken or are planning to take:
The centre will be reviewed to ensure all risks are identified and any hazards noted are carefully assessed, to ensure where risks are evident they are either eliminated, reduced, or minimised.

Proposed Timescale: 30/04/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The storage of oxygen cylinders was inappropriate and not in line with risk register and best practice.

9. 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:
The storage of oxygen within the centre has been moved to a new designated area with appropriate signage in place. The risk register has been updated to reflect these changes.

Proposed Timescale: 22/01/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Standards of hygiene and dual use of sluice and cleaning room were an infection prevention and control risk.

10. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
An alternative cleaning room has been sourced within the home and works have been completed to ensure it meets the criteria required. The new cleaning room is fully functional and currently in use.

Proposed Timescale: 28/02/2016

Theme:
Safe care and support

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

Staff in the centre were using one lancing device suitable for single patient use on multiple residents with a new lancet needle for each resident. This practice posed a risk of cross infection and was not in line with advice published regarding risk management of blood glucose monitoring in designated centres.

11. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
All residents now have their own lancets in place which are labelled and stored in their rooms to prevent any cross contamination and/or infection.

Proposed Timescale: 15/01/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire doors in six resident's bedrooms were found to be wedged open.

12. Action Required:
Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
The resident's that request to have their doors open now have a care plan in place reflecting this choice.

FirstCare are in consultation with an external consultant in relation to appropriate arrangements around resident's bedroom doors and the safety features that can be utilised to ensure residents are safe. Separately, FirstCare are awaiting clear recommendations and guidelines from HIQA in relation to what's is expected nationally regarding best practice.

Proposed Timescale: 30/06/2016

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The inspectors reviewed a number of the prescription and administration sheets and

identified a number of issues that did not conform with appropriate medication management practice:
- A number of residents required their medicines to be crushed prior to administration and this was documented at the top of the prescription sheet. The prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.
-The prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines and in some cases the times of administration were not clearly indicated (the prescription did not consistently indicate if the medicine was to be administered once daily or twice daily etc.)
-The indication for use of PRN (as required) medicines was not consistently documented on the prescription sheet and there were no associated resident specific care plans in place for these medicines to guide staff in the administration of these medicines (in some cases residents had been prescribed more than one psychotropic medicine on a PRN basis but the prescription did not indicate when the medicines were to be used or which medicine was to administered first. There were no protocols in place as part of behaviour support plans or care plans to guide practice to ensure appropriate consistent administration)
-The maximum daily dosage for PRN (as required) medicines was not consistently indicated on the prescription sheet. In some cases the dose and route of administration were not clear and there was no further information available in care plans to guide staff.

13. 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:
All issues noted at inspection have been attended to by Nursing Staff in liaison with the GP's. (completed - February 29th, 2016)

FirstCare are implementing a computerised medication management system at present and the issues noted and raised in relation to prescriptions will be rectified with this system. (Proposed Timescale – Year end 2016)

All care plans for residents using PRN medication will be reviewed by nursing staff to ensure they give clear guidelines to all staff in relation to the indications and/or reason for use. (Proposed Timescale – 30th May 2016)

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:
The complainant was not informed of the outcome and given details of the appeals process.

14. Action Required:
Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

Please state the actions you have taken or are planning to take:
The complaint in question in relation to laundry was dealt with immediately upon receipt by the Home Manager. However, the subsequent findings and resulting actions were not communicated in writing to the complainant. FirstCare have a local policy which indicates all complainants should receive written correspondence of the agreed outcome of their complaint and the process by which they can appeal same both internally with FirstCare and externally through other third parties. This has been highlighted to all staff and reiterated at management level.

Proposed Timescale: 15/01/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The size and layout of the premises not fully reviewed as part of any staffing review.

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

Please state the actions you have taken or are planning to take:
The Operations Team and the Home Management Team have completed a comprehensive review of the current staffing levels based on the number of residents presently residing in Blainroe Lodge, their dependencies, the skill mix of staff and the layout of the home. FirstCare recognises that there is no single tool available to assess the required staffing needs for a Nursing Home and accepts that the evidence supports the fact that several tools are required. The RIQA Staffing Tool used indicates that our current staffing level is sufficient to:

☐Meet and support the assessed needs of the current residents
☐Maintain resident safety within the home
☐Support choices around resident care and how its delivered

FirstCare has a plan in place to ensure the staffing levels are reviewed monthly, or

sooner if indicated, due to, changes in resident numbers, changes in dependencies, and new admissions. FirstCare will use the new evidenced based staffing framework published by the Department of Health in tandem with the RIQA Staffing Tool to underpin and inform all decision making around staffing in the home and to ensure the assessed needs of residents are met and sustained within a safe environment.

In addition the governance, management and supervision of staff on the floors within the Nursing Home has been enhanced with the addition of an extra CNM role within the home. Clinical Nurse Managers in liaison with the Home Manager, have the autonomy to review and revise the resources available within the home on a daily basis (or as the need arises), and how they are distributed. The two Clinical Nurse Managers perform a dual role in supervising and supporting staff as well as having a role in the direct care of residents.

The Clinical Team is supported greatly by the Pre-Registration Nurses that are currently working in the home whilst awaiting their NMBI Pins. Blainroe Lodge currently has 3 Pre-Registration Qualified Nurses working in addition to the staff compliment agreed with Senior Management following review of staffing levels.

FirstCare are satisfied that the present staffing supports the current number of residents based on their assessed care needs. There are clear pathways in place to ensure that when needed, the Management Team within the home have the autonomy to escalate the issue immediately to ensure the safety and protection of residents in the nursing home.

The Management Team in Blainroe Lodge will continue to formally review staffing levels monthly (or sooner if required) with the Operations Team and amend and adjust as required. The Home Manager and two Clinical Nurse Managers continue to review staffing on a daily basis, to ensure the needs of the residents are met and staff are distributed through the home in a manner that promotes safety, resident choice, and meets their care needs.

Proposed Timescale: 31/03/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No evidence of training in the use of psychotropic medication management.

16. 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:
All nursing staff have received training from an external provider in the use of psychotropic medication (as mentioned in Outcome 7). FirstCare will continue to ensure

this training is refreshed on a regular basis and all new nursing staff will receive same within the first 3 months of commencing employment.
Proposed Timescale: 10/02/2016