<table>
<thead>
<tr>
<th><strong>Centre name:</strong></th>
<th>Glencarrig Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre ID:</strong></td>
<td>OSV-0000043</td>
</tr>
<tr>
<td><strong>Centre address:</strong></td>
<td>Glencarrig Court, Firhouse Road, Dublin 24.</td>
</tr>
<tr>
<td><strong>Telephone number:</strong></td>
<td>01 451 2620</td>
</tr>
<tr>
<td><strong>Email address:</strong></td>
<td><a href="mailto:info@glencarrignursinghome.com">info@glencarrignursinghome.com</a></td>
</tr>
<tr>
<td><strong>Type of centre:</strong></td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td><strong>Registered provider:</strong></td>
<td>Nucare Company Limited</td>
</tr>
<tr>
<td><strong>Provider Nominee:</strong></td>
<td>Siobhan Launders</td>
</tr>
<tr>
<td><strong>Lead inspector:</strong></td>
<td>Leone Ewings</td>
</tr>
<tr>
<td><strong>Support inspector(s):</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Type of inspection</strong></td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td><strong>Number of residents on the date of inspection:</strong></td>
<td>23</td>
</tr>
<tr>
<td><strong>Number of vacancies on the date of inspection:</strong></td>
<td>2</td>
</tr>
</tbody>
</table>
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.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
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 National Standards. This monitoring inspection was un-announced and took place over 2 day(s).

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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 September 2016 10:00</td>
<td>15 September 2016 17:30</td>
</tr>
<tr>
<td>20 September 2016 10:00</td>
<td>20 September 2016 18:00</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider's self assessment</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
<td>Non Compliant - Major</td>
</tr>
</tbody>
</table>

**Summary of findings from this inspection**

This was an unannounced inspection conducted by one inspector over two separate days. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspector focused on six outcomes and followed up on one outcome from the last monitoring inspection which took place on 11 September 2014. There were 23 residents at the centre, the remaining two registered beds were vacant until the new person in charge was recruited by the provider.

Eleven of the 23 residents in the centre had a diagnosis of cognitive impairment, Alzheimer's disease or dementia. A further three residents were suspected of having a cognitive difficulty. However, the records of cognitive assessment shown to the inspector indicated that some residents were 'unable' to complete a formal assessment. The centre did not have a dementia specific unit.
Prior to the inspection the provider had been requested to complete a self-assessment document and review relevant polices. The judgments in the self-assessment stated four outcomes were in full compliance. One outcome, premises was a moderate non-compliance and safeguarding and safety was in substantial compliance.

The findings of this inspection were that there was major non-compliances with the premises and procedures in place for Garda Vetting of staff prior to employment, and staff recruitment. The inspector issued an immediate action to the provider, and requested assurances that staff would not be employed at the centre without evidence of Garda Vetting. The provider confirmed this with written assurances in the immediate action plan response. After the inspection further confirmation was submitted by the provider on 4 and 11 October 2016. Moderate non compliance was also found in one outcome - staffing. Substantial compliance was the judgment with the remaining three outcomes inspected.

The inspector found that the centre met most of the care needs of residents with dementia, and operated in line with the statement of purpose. Nonetheless improvements were required. Information was available for residents and relatives about dementia and residents' health care needs were well met. Responsive behaviours were found to be well managed by staff with good communication techniques, with activities in place each day.

The staffing in place including numbers and skill mix were found to meet the needs of residents. Staff demonstrated skills and knowledge required for them to care for residents who had dementia. Staff were kind and respectful at all times, and available to residents and relatives. Residents with dementia had their choices in relation to all aspects of their life and their personal choices were fully respected by staff. The management of complaints was found to be satisfactory.

The premises required substantial improvement to ensure it enabled residents with dementia to live comfortably and ensure the privacy and dignity of those residing there. The provider's action plans to address improvements to the premises from the last inspection had not been fully addressed. Some improvements were found to shared accommodation and storage at the centre. Nonetheless the findings of this inspection were that further improvements were required for one three-bedded room. The inspector also found that dining arrangements were not satisfactory for all residents. The premises did not ensure suitable and sufficient day and dining spaces for all residents. Further improvements were required with the premises, and provision of assistive equipment. The maintenance and ongoing care of the premises, both internally and externally was not adequate.

Changes to the management team had occurred since the last inspection. The person in charge had left her role in the centre on 10 July 2016, interim arrangements for cover were submitted by the provider. Two new deputy managers had been appointed since the last inspection, one of whom was taking on the temporary role as person in charge. The provider has been in her role at the centre as systems manager, since the time of the last registration renewal application.
However, some of the findings of this thematic inspection as evidenced under outcomes 2, 5 and 6 do not demonstrate good governance, or a good knowledge of the Health Act 2004 Care and Welfare Regulations 2013 (as amended) or the National Standards of Care for Older Persons 2016.

The Action Plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre’s for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland.
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:
Residents' wellbeing and welfare was found to be maintained to an adequate standard. Care plans and medicines management reflected individual care practices. However, some improvements were required with supports in place at mealtimes. This outcome was judged to be compliant in the self-assessment. The inspector judged it as substantial compliance.

Each resident's assessed needs were set out in care plans which identified their needs and interests. The admissions policy in place set out how each resident's needs would be assessed prior to admission, on admission and then reviewed at regular intervals. A review of the residents' records showed that this was happening in practice. Care plans were created on admission and developed as the staff got to know the resident better. The inspector confirmed that care plans were in place for psycho-social care, and these provided adequate guidance for staff involved in care provision.

The pre-admission assessment completed would consider if the centre would be able to meet the residents' assessed needs. For residents admitted under Fair Deal, the common summary assessment forms (CSAR) were available. These documents identified a multi-disciplinary detailed assessment of each resident's needs, and an assessment of each persons' cognitive abilities. The provider and the person in charge visited the resident at home or in the acute setting to complete a pre-admission assessment. The residents preferences relating to single or shared rooms was also found to be noted in the records.

Residents could retain their own general practitioner (GP) if this was feasible. Arrangements were in place for all residents to access medical practitioner services. Records reviewed confirmed that where medical treatment was needed it was provided in a timely manner. Referrals had been made to other services as required, for example, dietitian, speech and language therapist, optician and dentist. Some improvements relating to provision of assistive equipment was identified. For example, some residents were seen eating their meals at low side tables which did not fully meet their needs. On the first day of the inspection the inspector also saw one resident using a domestic
armchair which was unsuitable. This resident had been referred for an occupational therapy seating review this had not yet been completed to date. The person in charge confirmed on day two of the inspection that an alternative chair had been sourced on an interim basis.

The person in charge or registered nurse completed a detailed assessment for the residents. The records completed showed the detail of how to support the residents in relation to their identified needs. For example; communication, nutrition, daily living skills, mobility and pain management.

A detailed life history document was implemented by staff and involved resident, relatives and activities staff. Memory and familiar items in residents' room along with items of reference for each resident were in place to assist with settling in. The records reviewed reflected important personal information and events in each resident's lives.

Records also showed that where there were known risks related to a residents care they were set out in the care planning documentation on admission. The documentation reviewed relating to nursing assessments completed. For example, most records reviewed had up to date risk assessments in place for the use of bed rails. Nonetheless, the actions following a resident's fall involving the use of a bed-rail had not been fully risk assessed post this incident. This matter was actioned by staff on duty on the first day of the inspection, and measures to mitigate the risk of recurrence were put in place and confirmed on the second day of the inspection.

Adequate behavioural support care plans were in place to inform and guide staff prior to the use of any form of restrictive practice. One resident was identified as becoming agitated and may have some exit seeking behaviours. The inspector found this was well managed and the care plan reflected the re-direction techniques which were in place to guide staff.

Care plans were informed by assessment information and were seen to include health and social needs, with information about residents social, emotional and spiritual needs included. Areas such as each individuals understanding of their health care needs were covered in the documentation, and end of life care wishes (where appropriate). Where residents had religious or spiritual beliefs, this clearly was recorded in their care plan.

Medicines management was observed to be well managed. The nursing staff demonstrated a person-centred gentle approach to administering medicines. Practices were found to be safe and documented fully in line with Nursing and Midwifery Board of Ireland (NMBI) guidance.

The mealtime experience required review to ensure all residents' needs could be met in a timely manner. Residents' preferences for where they ate their meals was documented in the records. Some residents identified to the inspector, who required additional support with meals, had their meals in the main sitting room. However, the tables and surfaces in place required review. A small number of residents chose to eat their meals in their bedrooms and other more mobile residents went to the dining room. One observation took place during a mealtime in the sitting room. Some residents sat next to nearby residents eating their meals whilst waiting for their own meal. Service was
staggered and kitchen staff were observed participating in assisting residents to eat at mealtimes. Supervision was in place, however, the medicines were also being given by the nurse at the same time as lunch service. This practice requires review to ensure adequate supervision is in place in both the dining and day rooms.

**Judgment:**
Substantially Compliant

### Outcome 02: Safeguarding and Safety

**Theme:**
Safe care and support

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

**Findings:**
Some evidence that measures were in place to protect residents from being harmed or suffering abuse was found. Most staff had been provided with up-to-date training on the prevention and responding to reports of elder abuse. All staff spoken to were clear on their roles, and their responsibilities in terms of reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, and responding to and managing abuse. Nonetheless, it was found that some staff had been engaging in practices which were not person-centred, including the use of communal cloths for washing. This practice was brought to the attention of the provider and senior staff. Disposable hygienic wash-cloths were in place on day two of this inspection.

A review of the use of restraint found that there were 10 bed rails in use throughout the centre. Some efforts to promote a culture of a restraint free environment were evidenced. However, alternatives to the use of bed rails were not be consistently evidenced as tried. Practice was not fully in line with national policy, as outlined in Towards a Restraint Free Environment in Nursing Homes (2011). The provision of other alternatives, such as ultra low beds to facilitate continued reduction in the use of mechanical restraint use was required. This had not yet been actioned or fully considered as part of the written risk assessment. The policy on restraint had been updated in July 2016 but had not been fully implemented to date. Staff required additional training and education in the area of the assessment of restraint. This is referenced also in Outcome 5 of this report.

The inspector reviewed the system in place to manage residents' money and property and found that small sums of money were held in a locked cabinet, and this was documented. These processes were discussed with the provider who informed the inspector that she was not involved with the financial management of residents' monies, and did not act as a pension agent.

**Staff interactions with residents was found to be respectful and measured. Residents'**
dignity was maintained as required, and support and assistance with aspects of care such as mobility was gentle and professional. Residents who spoke to inspectors said they felt safe. Nonetheless, appropriate safeguarding measures and safe and effective recruitment processes were not found to be in place. Evidence of Garda vetting disclosures for five staff named on the staff roster was not available. One staff member working on the first day of the inspection had not completed a full induction training, including safeguarding. This was brought to the attention of the provider prior to the end of the inspection. This staff member was taken off the roster on this date.

The staff files were not on-site at the time of the first day of the inspection, and these were requested by the inspector to be available on day two. The provider ensured that the files were available as requested and the records were reviewed by the inspector. An immediate action was issued to the provider with two weeks given to her to address this major non-compliance. The provider forwarded evidence that the vetting disclosure had been received following the inspection on 4 and 11 October 2016. Written confirmation was received that staff would not be working at the centre in the interim whilst evidence of Garda Vetting disclosures were sought.

This outcome was judged to be substantially compliant by the provider in the self-assessment and the inspector judged it as major non-compliance.

**Judgment:**
Non Compliant - Major

---

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

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

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

**Findings:**
Residents in the centre were consulted with about how the centre is run. A gentle approach to caring for residents with dementia was evidenced. Residents' rights were promoted and their dignity was respected. Some improvements were required including the use of one three-bedded room, in terms of layout that did not ensure privacy.

The inspector observed staff and resident interactions throughout the day. Staff were observed to be calm and spoke to residents in a kind and friendly manner. Staff and residents were observed to be chatting throughout the period of the inspection. The inspector observed staff knocking on doors before entering resident's bedrooms. The inspector observed staff gently re-directing a resident who appeared a little agitated and this helped put the resident at ease. When resident's refused to take medication this right was respected. Staff would return at a later point and see if the resident had changed their mind.

Staff informed the inspector that there was a visitors' policy, including a visitor's book.
and hand hygiene at the front door area. This was observed to be the case and residents could receive visitors throughout the day. Visits took place in private either in bedrooms or in a small visitor's room. This room was noted to be small, with no natural lighting and could not easily accommodate assistive chairs through the narrow corridor. This room was also used for other purposes by staff during the inspection (see Outcome 6: Safe and Suitable Premises).

There was an activities plan in place for the centre. During the inspection the activities were held in the sitting room. There was access to a landscaped and enclosed safe back garden for residents. The door to the decking area is ramped through the conservatory space, which is also used for residents who smoke at the centre. No residents were observed to use the decking areas and seating available. One part of the sitting room had a lot of natural light and had an open seating area. Some residents told the inspector that this area was warm and they liked to sit in the sunshine. Some residents also used the corridors and hand-rails to take walks in the centre, some were accompanied and others like to walk alone independently.

Residents had access to an voluntary independent advocate. Contact details for the advocates were on listed under the complaints procedure. Residents' meetings took place. Any issues raised by residents during these meetings were submitted to the management of the centre, so they could be addressed and put into practice if possible.

Residents' religious needs were observed to be met in the centre. Staff informed the inspector that a monthly mass was held in the centre to which residents could attend if they wished. Residents had access to a wireless land-line telephone. Newspapers were available to residents on a daily basis. There was access to television, radio and internet in the centre.

Residents' civil rights were respected in the centre. Residents were supported to visit the local polling station. Less mobile residents were also facilitated to vote in the centre.

Three three-bedded rooms were in use at the centre. Two were found to have adequate screening and storage, with furniture in place to meet the residents' assessed needs. One bedroom layout was poor, with residents' clothing and belonging stored across one wall, which required entering the another resident's space. This was also the case to access the hand washing facility stored in a wardrobe space. A resident's locker and personal items further restricted access to the hand washing sink.

This outcome was judged to be compliant in the provider's self-assessment and the inspector judged it as substantially compliant.

**Judgment:**
Substantially Compliant

**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 complaints policy in place. However, it was not been updated with the
details of how complaints were managed following changes in management. An
outdated copy was on display in the centres' front hall. The policy and procedures had
not been updated following changes in governance in the centre. This was updated
following a discussion with the provider.

Residents' told the inspector that they would complain to the person in charge, provider
or any of the staff. The two complaints recorded since the last inspection were
reviewed. All feedback including verbal issues raised were recorded showed that they
were all dealt with promptly by the provider and person in charge. The outcome of the
complaint and the level of satisfaction of the complainant was recorded.

There was an appeals process outlined in the procedure but none of the complaints
outcomes on file had been appealed.

This outcome was judged to be compliant in the provider's self-assessment and the
inspector judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
There were appropriate staff numbers and skill mix to meet the assessed needs and
dependency of residents and for the size and layout of the centre. Staff had received
training and education about communication and dementia care, and spoke
knowledgeably about best practices.

The inspector reviewed staff turnover and staffing with the provider. The provider
confirmed that she did not have any concerns about excessive staff turnover at the
centre. She had completed a staffing review and showed this review to the inspector,
and confirmed that this was an ongoing process.

On arrival at the centre on the first day of the inspection, one registered nurse and five
care assistants were on duty. One care staff was assigned the role of both caring and to
complete the laundry after morning care duties. Another staff member is allocated to lead out on activities. Additional staff including kitchen, household and a systems manager were also on duty. The provider and staff rosters confirmed that two registered nurses were usually on duty each morning. On the first day of the inspection a second staff nurse was on unanticipated leave. However, a care staff member who had been accompanying a resident to a hospital appointment was able to stay on until a second staff nurse came in the early afternoon. Staffing rosters were reviewed and it was confirmed that two staff nurses and five care assistants were the usual morning staffing.

The provider had notified a change of person in charge had taken place on 10 July 2016. She submitted details of the interim arrangements whilst recruitment was ongoing. A new person in charge had been appointed, and was found to have left the position after three weeks, no recruitment or Schedule 2 records were available to review, and HIQA had not been furnished with full and complete information about the new person in charge. A deputy manager had been appointed by the provider in the interim, and she was now working in the role of person in charge. She was supported by a further senior nurse who deputised as required. The provider had undertaken to keep admissions at 23 residents and leave two beds empty until the recruitment process for the person in charge was completed. However, the inspector found that insufficient management hours were allocated to the staff member to complete some aspects of the role.

Records reflecting registration details of staff nurses for 2016 were available for review. The majority of staff had up-to-date mandatory training in place. Staff had also received education and training to enable them to meet the needs of residents with dementia and could give examples to the inspector relating to practice improvement as a result of training. Staff had also received a range of training on how to managing responsive behaviours and communication. This was evident in the approach and how the staff interacted with residents with dementia. Some further training in assessing and managing restraint in line with best practice was identified to the provider.

There were practices which showed that staff practices were based on person centred practices. For example, care staff demonstrated open communication and offered choice frequently during the observations. Staff were observed not to be hurried and were patient in terms of all interactions and with personal care, activities and meals.

There was an actual and planned staff roster which reflected staff on duty. No agency staff were used. However, bank staff were used to cover mainly night duty. Arrangements were in place to handover to night staff and update them about any changes in residents' condition and assessed nursing needs.

This outcome was judged to be compliant in the self-assessment, the inspector judged it as a moderate non-compliance.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises
<table>
<thead>
<tr>
<th>Theme:</th>
<th>Effective care and support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong></td>
<td>Some action(s) required from the previous inspection were not satisfactorily implemented.</td>
</tr>
<tr>
<td><strong>Findings:</strong></td>
<td>At the time of the last inspection there was a lack of suitable space for storage of equipment, limited communal and private space and limited space in the laundry and dirty utility. In addition there were three three-bedded rooms which required review to meet the requirements of our Standards and one other bedroom was of insufficient size. The provider had submitted a proposal for re-configuration and extension to the existing premises, with a time frame which was agreed with HIQA. However, following a request for an action plan update in March 2016, the provider had not progressed with this proposal to date. The provider informed HIQA that planning permission was sought and received in 2014 to undertake the necessary works to come into compliance. The National Standards for Residential Care Settings for Older People in Ireland (2016) are now in place, from July this year to guide providers of care in designated centres. The premises at the centre do not fully meet these requirements, and were not found to be suitable and sufficient to meet the needs and dependency of all residents living at there.</td>
</tr>
<tr>
<td></td>
<td>The centre was found to be warm and in the main comfortably furnished. Corridors were kept clear and uncluttered to ensure resident safety when mobilising. There was a functioning call bell system in place within the centre, and hoists and pressure relieving mattresses were in working order. Storage of moving and handling equipment and commode chairs in the shower room, was not found to be appropriate and could be a hazard when using this room to both staff and residents. Two shower rooms were available to 23 residents on the day of inspection which is outside the requirement for a minimum of one shower/bath room to eight residents.</td>
</tr>
<tr>
<td></td>
<td>Furniture surfaces in some residents bedrooms was subject to visual evidence of wear and tear/damage, and would be difficult to clear should a deep clean be required. The material coverings of some chairs in the day room were exposed and damaged. Excessive food debris was seen on a number of residents chairs, between cushion and on the arms of chairs. A small side table, could not be adjusted for a resident at lunch-time, and this table was found to be damaged and required repair.</td>
</tr>
<tr>
<td></td>
<td>Communal space was available in the sitting and dining rooms, and small conservatory/sun-room. A separate quiet small visitor's room was also available. The sum total of space available at present does not meet the minimum spatial requirement for 23 residents. Chairs were arranged against the walls of the day room and the dining room could not accommodate any more than 12 residents at one sitting. Access to the laundry was down a step from the dining room, and this room was not found to be adequate in terms of a suitable area to sort and manage laundry.</td>
</tr>
</tbody>
</table>
| | Appropriate signage and cueing to support freedom of movement for residents with dementia was not in place. There were some small picture cues placed on some of the
doors but contrasting colour cueing on bedroom or bathroom doors or contrasting toilet seats were not in place. The flooring in corridors was dark brown carpeting in with a number of joins along the length of the corridor with metal bars.

There were six single bedrooms (one en-suite), five twins and three triple bedrooms in the centre. One bedroom was not meeting the minimum criteria at the time of the last inspection. The bedrooms were personalised to reflect residents' individual wishes with some pictures photograph's and mementos. Repairs to the door of one three-bedded room were noted. Wear and tear was noted on the wooden door frames from wheelchairs.

The premises and grounds required additional maintenance including a small visible area of external damage to roofing tiles, and guttering which was overgrown in places. An enclosed partially paved rear garden was available for resident's use. The inspector saw the external pathways and means of escape from the fire doors were partially covered in thick green moss-like substance. Some wooden garden chair seats on the decking were broken and unsafe for resident use. The provider confirmed that the maintenance person would action these matters at the time of the inspection. The provider discussed her plans to undertake renewal of flooring at the centre.

Grab rails and hand rails were installed where required, including in toilets. The ceiling of the shower room nearest the front door area, showed evidence of water marks.

**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:**

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
**Provider’s response to inspection report**

**Centre name:** Glencarrig Nursing Home  
**Centre ID:** OSV-0000043  
**Date of inspection:** 15/09/2016  
**Date of response:** 13/12/2016

**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:**

The mealtime experience required review to ensure all residents' needs could be met in a timely manner.

**1. Action Required:**

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

---

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
We appreciated the Inspector’s comments on this matter and immediately reviewed our mealtime routines to enhance our Residents’ mealtime experience and to ensure that all residents’ needs are met in a timely manner:
• Medication is now given after mealtimes so that Residents can enjoy their meal without interruptions
• Nurses assist and provide clinical supervision in both the dining and day rooms during meals. They also provide ongoing monitoring of each Resident's mealtime experience at every meal.
• Residents who prefer to dine in their rooms and require assistance with their afternoon or evening meals are served first so that sufficient staff are then available to assist in the dining / day rooms without the need for any Resident to have to wait for assistance while others are having their meal.
• In order to promote the independence of some residents, assistive tableware is being sourced, e.g. specialised plates, cups, cutlery, tailored to individual resident’s needs.
• Seating arrangements are being looked into in consultation with the Residents to see what improvements they would like to see and that are practicable.
• New tables for day room use during meals have been sourced and are due to arrive on 16/12/16.

Our Residents’ mealtime experiences are monitored by our PIC and Senior Nurses on a daily basis through supervision as well as feedback from our Residents. This is reviewed on a monthly basis by both the Provider and PIC incorporating feedback from our Residents’ meetings.

Suggestions for improvement regarding the food, choices, presentation, assistance given, seating arrangements, ambiance or facilities is actively sought from both the Residents and staff and actioned immediately or as soon as it is practical to do so.

Proposed Timescale: Completed 27/09/16 and Ongoing.

Proposed Timescale: 27/09/2016

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:
Alternatives to the use of bed rails were not evidenced, and practice was not fully in line with national policy, as outlined in Towards a Restraint Free Environment in Nursing Homes (2011).

2. 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
Please state the actions you have taken or are planning to take:
All residents assessed for the use of bed rails are always risk rated using the HSE risk-balancing tool and re-evaluated daily by the senior nurse on duty and also monthly by the PIC. Our restraint risk-register is updated every month, or sooner as required, and is currently being reviewed by our new PIC.

Alternatives to the use of bed rails and trial discontinuations of bed rails are now fully documented. In the last 2 months we have made a significant reduction to the number of bed rails currently in use and have gradually reduced this by 4 through trial discontinuations and provision of additional supports where needed. We aim to continue trial discontinuations on a planned basis over the next 2 months with our remaining Residents. Impacts on Residents of discontinuing the use of bed rails is monitored and documented through our ‘Trial Discontinuation of Bed Rails’ and ‘Alternatives to the use of Bed Rails’ record sheets and are discussed at every handover, twice daily, to update all staff as to the success or problems / new risks encountered.

Progress in our reduction of the use of restraints, impacts on Residents, re-evaluation of risks and outcomes are being reviewed weekly and will be documented as part of the weekly Provider – PIC meetings.

Over the last 2 years, 2 Residents had been assessed as needing low-low beds (as an alternate to bed rails) and 1 resident was assessed as benefitting from crash mats and these beds and mats had been immediately provided. During our recent trial-discontinuations 1 Resident was further assessed as needing an ultra-low bed and a new ‘floor-bed’ as well as a safety bed alarm have been sourced and provided for them. A further set of crash mats as well as a range of repositioning devices have also been purchased to further support our Residents’ changing needs. As our trial-discontinuations continue, our Residents needs change or new Residents are admitted further supports and equipment will be provided as per their assessed needs.

Our entire practice around the area of restraints has been reviewed to bring it in line with both our own policy and national policy. We will continue ongoing reviews with a view to further reductions as much as possible. Our practice in the area of restraints will be active, ongoing and regularly assessed and results discussed at staff meetings.

Proposed Timescale: Completed 23/11/16 and ongoing

Proposed Timescale: 23/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Evidence of Garda vetting disclosures for five staff named on the staff roster was not available.
One staff member on duty had not attended safeguarding training.

3. **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:**
All vetting disclosures and safeguarding training are now in place for all staff. As committed to the Inspector on the day, we will ensure that there will be no deviations from statutory or regulatory requirements in the future and that all new staff will have both their safeguarding training and vetting disclosure in place prior to commencing their duties in line with our Recruitment policy.

**Proposed Timescale:** 11/10/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Schedule 2 staff files with records of recruitment procedures were not available for inspection on first day of the inspection.

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:**
Schedule 2 staff files with full records are now kept in the designated centre.

Proposed Timescale: Completed during the Inspection (20/10/16)

**Proposed Timescale:** 20/10/2016

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

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The visitor's room did not have natural lighting and was small and was not fully accessible to all residents.

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

Please state the actions you have taken or are planning to take:
We acknowledge that the Visitor’s room has limitations under the current configuration of the designated centre however Residents and their families have always been offered the additional choice of using either the conservatory or the dining room to meet in private if they would prefer to, one or the other of which is guaranteed to be available at all times. Both Residents and their visitors have always been happy with this arrangement and regularly use all three options when they would like some privacy. Staff use of or access through any of these rooms is always secondary to the needs or wishes of our Residents, their families and visitors. This is monitored on an ongoing basis by the senior nurse on duty and reviewed daily by both the PIC and Provider.

Proposed Timescale: Ongoing - Reviewed daily as per our Residents needs or wishes

Proposed Timescale:

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Storage in one three-bedded room did not ensure that each residents clothing and personal property was readily accessible to them at all times.

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

Please state the actions you have taken or are planning to take:
This bedroom has been completely renovated to make it more spacious and to provide individual wardrobe, storage and locker space beside each resident’s bed to enhance their privacy. This reconfiguration also ensures unrestricted access to the hand washing sink.

Proposed Timescale: Complete reconfiguration of this bedroom, including plumbing, wiring, painting and decorating were all completed by 22/11/16. The new purpose built wardrobes have not yet been installed due to shipping delays however replacement wardrobes have been installed in their place until the new ones arrive (due 20/12/16).

Proposed Timescale: 20/12/2016

Outcome 04: Complaints procedures

Theme:
Person-centred care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A copy of the most up-to-date complaints procedure was not displayed in a prominent place at the time of the inspection.

7. Action Required:
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

Please state the actions you have taken or are planning to take:
The up-to-date complaints procedure is now displayed in the foyer.

Proposed Timescale: Completed during the Inspection (15/09/16)

Proposed Timescale: 15/09/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One registered nurse on duty working to deliver care for 23 residents, and undertake all nursing roles including supervision of staff.

8. 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:
Our second nurse scheduled to work that morning had unfortunately taken ill. Despite every attempt being made, no replacement nurse was available immediately on this occasion, however an additional carer was available to assist with morning care and a replacement nurse arrived at 11am.

All of our staff are highly committed to both our residents and our Nursing Home and are usually available to provide cover in such circumstances as per our back-up plan. We also have a number of committed and reliable bank staff, including nurses, carers, kitchen and domestic staff, who can and do provide additional cover whenever needed.

Our bank staff are informed of any recent changes in our Residents’ needs or our work practices by the senior nurse on duty as soon as they arrive (either at the handover or individually as appropriate) and these changes are further detailed in our communications book and up-to-date information sheets and records specific to each assigned task.
We review our staffing needs on a monthly basis or sooner if the assessed needs or supports of our Residents change. Further to this, we review our staffing contingency arrangements on a weekly basis to ensure, as far as possible, that replacement staff are always available.

Proposed Timescale: Ongoing

Proposed Timescale: 15/09/2016

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff induction procedures did not include all aspects of mandatory training including safeguarding and moving and handling prior to commencing duties.

9. 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:
We are fully committed to ensuring that there will be no deviations from statutory or regulatory requirements in the future and that no staff will commence their duties prior to receiving mandatory training in line with our Recruitment policy.
Proposed Timescale: Completed 15/09/16 and Ongoing

Proposed Timescale: 15/09/2016

Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Registered nurses had not received training in restrictive practices in line with national policy.

10. 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:
One of our nurses had recently attended restraint training on the 9th of September and two of our nurses had completed webinar training on restraints on the same day. More in-depth training for our nurses was investigated and provided on the 17th of November.
Proposed Timescale: 17/11/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provider could not evidence that staff working as volunteers had Garda Vetting disclosures in line with the regulations.

11. **Action Required:**
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
The vetting disclosures for our volunteers have since been located and are now stored alongside the Staff files to ensure they are readily available for all future inspections.

Proposed Timescale: 14/10/2016

**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:
The internal and external premises was not well maintained including roof, gutters, pathways.
One internal ceiling in a shower room was water marked.
Furniture requires repair or replacement including chairs, bedside lockers, side tables.
Laundry is not an adequate size and not fully equipped with space to undertake ironing and sorting of clothing.
There is inadequate bathrooms in place for all residents use in this centre.
Bedroom accommodation requires review to ensure adequate space to ensure privacy and dignity for residents with suitable and sufficient storage, space to move around beds and access the hand washing sink.
Suitable storage space is not sufficient for moving and handling equipment and commodes.
Communal space does not meet the requirements of residents.
Flooring in sitting room and corridors requires review to ensure it is suitable and sufficient for required cleaning, as this space is used for residents eating meals on a daily basis.
The visitor's room has no natural light.
Access to decking outside area is through the smoking room.
External pathways and means of escape from the fire doors were partially covered in thick green moss-like substance. Some wooden garden chair seats on the decking were broken and unsafe for resident use.

12. **Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
The providers and our management team are fully committed to improve our compliance level and our staff are as committed as we are to creating the best possible home for our residents.

As discussed with the Inspector on the day various plans for re-flooring, refurbishing and renovation were in place. These unfortunately had not been actioned yet due to our more immediate and urgent priority of undertaking what turned out to be an extensive and lengthy search to find a suitably qualified and capable replacement PIC, putting in place interim arrangements for cover and ensuring the continued well-being of our Residents, high-standards of care and competent management of our Nursing Home. Now that our new PIC is in post we are delighted that we have been able to refocus on our refurbishing, renovations and other necessary works. Both Residents and staff are very excited about the current and upcoming renovations and have been consulted in all aspects including colours, styles, textures and time-frames.

Our Residents and visitors have a choice of accessing our garden and patio area either directly via our ‘Garden door’ or by going through the Conservatory. Both access points have nearby seating and table areas and are connected via pathways creating a pleasant circular walk. While our Conservatory is indeed our designated smoking area, it is seldom used as such as very few of our Residents smoke and it is more commonly used by Residents who are just relaxing, socialising or soaking up the sun.

**Schedule of Works already completed:**
- The chairs identified above were removed immediately on the first day of the Inspection, 15/09/16.
- The gutters were immediately attended to the following day, 16/09/16.
- The pathways were attended to by 23/09/16.
- Intensive cleaning of residents’ chairs was completed by 27/09/16.
- Roof tiles were repositioned or replaced as needed, completed 04/10/16.
- Shower room ceilings were found to be in good order with no signs of water marks or damage found, completed 06/10/16 and reconfirmed 03/11/16.
- The two bedrooms identified above have since undergone complete renovation completed 22/11/16 with the exception of new purpose built wardrobes. Alternate wardrobes have been installed until the new wardrobes arrive (due 20/12/16).
- An additional storage area for assistive equipment was created, completed 26/11/16.

**Schedule of Works in progress:**
- Bedroom furniture, including beside lockers, has been assessed for either deep
cleaning or replacement as needed and this will be completed by 10/12/16.
• New ‘day’ tables have been sourced and are due to arrive by 16/12/16.
• New flooring is due for installation on a phased basis 10/12/16 - 22/12/16.
  Outstanding flooring work, if any, will be continued in the New Year and completed by 17/01/17.
• New flooring is due for installation on a phased basis 10/12/16 - 22/12/16.
  Outstanding flooring work, if any, will be continued in the New Year and completed by 17/01/17.
• Decorating throughout the home including walls, ceilings, skirtings & door frames has already commenced on a phased basis and is due for completion by 30/01/17.
• An additional shower will be installed by 30/01/17.
• Contrasting colour cueing on bedroom & bathroom doors as well as contrasting toilet seats are being investigated and will be in place by 30/01/17 or earlier if possible.
• Alternative arrangements within our communal areas are being looked into in consultation with the Residents to see how best we can use those spaces to better meet their needs. We will trial a few different configurations over the next three months and the Provider and PIC will evaluate each one through staff observations as well as feedback from both Residents and visitors. Planned completion date 28/02/17.
• Plans for a new laundry arrangement are being investigated with a planned completion date of 15/04/17 or earlier if at all possible.

Proposed Timescale: 15/04/2017