<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Consolation Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000079</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Arden Road, Tullamore, Offaly.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>057 932 1320</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:rosmycunningham@yahoo.ie">rosmycunningham@yahoo.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Our Lady of Consolation Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Rosmy Cunningham</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Siobhan Kennedy</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary O'Donnell</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
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<td>Number of residents on the date of inspection:</td>
<td>25</td>
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**About Dementia Care Thematic Inspections**

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

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 23 February 2016 07:30  
To: 23 February 2016 18:00

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>
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</thead>
<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td>Non Compliant - Major</td>
<td></td>
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<tr>
<td>Outcome 08: Governance and Management</td>
<td>Non Compliant - Major</td>
<td></td>
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<tr>
<td>Outcome 09: Statement of Purpose</td>
<td>Non Compliant - Moderate</td>
<td></td>
</tr>
<tr>
<td>Outcome 12: Notification of Incidents</td>
<td>Non Compliant - Moderate</td>
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**Summary of findings from this inspection**

This inspection was conducted with a special focus on the provision of dementia care. Inspectors wished to evaluate the quality of life for people with dementia living in the centre. The inspectors focused on six outcomes that had direct impact on dementia care and followed up on the actions from the previous two inspections in Feb 2014 and May 2014, many of which were not completed.
Prior to the inspection, the provider had submitted a completed self assessment on dementia care to the Authority, together with relevant policies and procedures. The inspection findings and the self assessment judgments in relation to six outcomes relevant to dementia care are presented in the table above. Inspectors also monitored four additional outcomes, governance and management, health and safety, statement of purpose and notification of incidents. Two moderate and two major non-compliant outcomes were found.

Inspectors reviewed documentation such as care plans, complaints and medical records and information regarding staff working in the centre. Inspectors met with residents and staff members. They observed care practices and interactions between staff and residents using a validated observation tool. Inspectors tracked the care of four residents since admission.

On the day of the inspection 7 residents were assessed as having dementia. There was no specific dementia unit.

The findings of the inspection highlighted the following: –
• Health-care needs of residents were primarily met with good access to medical and allied health care and a reduction in fall/accidents. However, improvements were required in relation to medication management, assessment, care planning and record-keeping.
• Measures to protect residents with dementia being harmed or suffering abuse were in place, however, all staff had not participated in training to safeguard residents.
• Residents with dementia were not consulted, did not participate in the organisation of the centre or were not engaged in meaningful activities.
• There was no person to monitor the recording and management of the complaints process.
• There were insufficient staff to meet the needs of residents and staff did not have access to appropriate training.
  • Storage space for equipment was inadequate.
  • The bathroom due for completion in June 2014 was not completed.
  • There was no plan to replace worn equipment or for the upkeep maintenance of the premises.
• Consideration had not been given to adaptations to maximise the functioning of residents with dementia.
• Effective governance and management systems had not been developed.
• The risk management policy was not fully implemented and all fire safety arrangements were not in place.
• The statement of purpose did not contain all the matters required as per the schedule and
• All notifiable incidents had not been notified to the Authority.

The areas of non-compliance are detailed in the action plan of this report.
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is covered in Outcome 3.

Overall, there were arrangements in place to meet the health and nursing needs of residents with dementia. Pre-admission and admission assessments were carried and care plans developed. However there were gaps in nursing assessments and care plans lacked sufficient detail to support the delivery of consistent care. The involvement of residents in the care planning process required improvement. Medicines were not stored securely and the timing of administration of some medications were not in line with prescriptions. This issue was a non compliance in Feb 2014. The nutritional and hydration needs of residents with dementia were not fully met. None of the residents had pressure sores or weight loss and the incidents of falls were low.

Residents had access to general practitioners (GPs) of their choice, and to allied healthcare professionals including dietetic, physiotherapy, speech and language, dental, ophthalmology and podiatry services. Residents also had access to the mental health of later life services, with onsite visits from psychiatry of later life team. Residents had access to the community occupational therapist but inspectors noted that one resident who would benefit from a seating assessment had not had a referral.

Inspectors focused on the experience of residents with dementia and they tracked the care of a four residents with dementia. They also reviewed specific aspects of care such as nutrition or wound care in relation to other residents.

There were systems in place to optimise communications between the resident/families, the acute hospital and the centre. Prospective residents and their families were invited to visit the centre and meet other residents and staff before making the decision to live there. The person in charge visited prospective residents in hospital prior to admission. This gave the resident and their family information about the centre and also to ensure that the service could adequately meet the needs of the resident. Pre assessment
documentation was available for inspection. This was entitled “Initial Admission Assessment” however; there was no date or signature of admitting nurse.

Residents’ records were available and contained copies of discharge letters/correspondence from hospital. Inspectors noted that the files of residents admitted under Fair Deal did not have Common Summary Assessments (CSARS) which detailed the assessments undertaken by a geriatrician, a medical social worker and a comprehensive nursing assessment.

Inspectors examined the files of residents who were transferred to hospital from the centre and found that the transfer letter contained information about the resident’s health, medicines and personal information. Relatives were informed if a resident was transferred to hospital and in the main would accompany the resident.

Residents had a nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident’s risk of malnutrition, falls, dependency level and their skin integrity. There was also a pain level monitoring tool for residents who were non-verbal. Gaps in the assessment process were identified. An assessment of residents’ level of cognitive function was not routinely undertaken. The assessment of a resident, who had a visual impairment due to macular degeneration, was not explicit regarding the extent of this and care staff assisting the resident did not have this knowledge.

A care plan was developed within 48 hours of admission based on the residents assessed needs. Inspectors found that care plans did not consistently contain the required information to guide the care of residents. For example statements such as ‘encourage fluids’ did not indicate the volume of fluid which should be taken. Inspectors noted that the care plan of a resident with impaired verbal communication did not contain a comprehensive communication plan which described this resident's non-verbal communication mode. In addition, care planning documentation did not contain all of the relevant records as per the schedule, for example residents' weights, referrals to allied health professionals specialist communication needs.

Care plans were updated routinely on a four monthly basis. The review in the majority of cases was not comprehensive and only stated that the review had taken place. Care plans were not updated to reflect residents' changing care needs or to include the amended/new care interventions. For example changes to the management of a resident’s urinary catheter were not reflected in the care plan. Generally care plan folders were too full, making it difficult to access information. In addition some pages were loose in the ring binder file. In one file a discharge letter from an outpatient department was not secured into the care plan notes.

There was documentary evidence that some residents and relatives, where appropriate had provided information to inform the assessments and the care plans. Each care plan had a section for the resident's dietary likes and dislikes and information about what time they liked to get up, have breakfast and retire at night. This information was not recorded in all the care plans viewed and the quality of the information gathered was inconsistent. At the top of each care plan it stated “this care plan has been discussed/agreed and drawn up with the involvement of resident or significant other”,

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however, this had not been completed in respect of residents who were case tracked. Information about residents’ hobbies and interests was recorded and levels of enjoyment relating to activates was generally documented in daily nursing notes and care plan reviews. The development of formal social assessments and life story work was an area for improvement.

Staff provided end of life care to residents with the support of their general practitioner and the community palliative care team. No residents were under the care of the community palliative care team at the time of inspection. One of the care plans examined had an 'End of life' care plan that outlined the residents wish not to be resuscitated, including the residents' preferences regarding their preferred setting for delivery of care. Single rooms were available for end of life care. However there was no evidence that the medical officer had been involved in the end of life discussions with the resident or that the resident's wishes would be respected in an emergency situation. End of life care planning was not in place for residents with dementia.

Residents were risk assessed and measures put in place to prevent pressure sores developing. Two static pressure relieving mattresses in use for the residents who were case tracked were found to be worn and not fit for purpose. A resident who had recently developed a diabetic foot ulcer had a wound assessment and a care plan in place. The resident had been referred for a vascular assessment.

Residents with diabetes were managed by the GP and referred to the diabetic clinic where appropriate. Staff described the procedure for measuring residents’ blood glucose levels; however the glucose monitor which was for use with multiple residents had not had the required daily quality controlled checks for over three months.

All residents were screened for risk of falls on admission and regularly reassessed thereafter. Care plans were in place based on the assessment. However they were not amended following a fall. Although interventions were put in place to prevent a reoccurrence and to mitigate the risk of injury from falls, there were no formal arrangements in place to review accidents and incidents within the centre. Inspectors analysed the incident reports for the previous 12 months and found that the incidence of falls was low. They judged that the action required following the previous inspection had been completed. Neurological observations were undertaken when a resident had an un-witnessed fall or if there was any risk of a head injury. This action was completed since the last inspection.

Health was promoted and residents had been offered the flu vaccine; however staff had not been offered the flu vaccine in line with recommended practice. Improvements were also required to support good hand hygiene practices. There were only two alcohol gel dispensers and the staff hand washing station was in the duty room, which had a key pad lock. Arrangements for disposal of clinical waste were not in line with recommended practice. The clinical waste bin was in the duty room beside the clean dressing trolley.

Residents had access to the pharmacist of their choice and the pharmacist was available to meet with residents if required. The pharmacist undertook audits of medication practices. The most recent audit was carried out on 25 November 2015. There were written operational policies relating to the ordering, prescribing, storing and
administration of medicines to residents which were not fully implemented in practice. Medicinal products had not been secured safely. The medicine trolley was left unlocked. Medicines including eye drops were observed left in residents’ bedrooms yet none of the residents self administer medicines.
The Drug Kardex for residents who were case tracked had been written in 2014 and erasing fluid had been used on two of the documents.

The inspectors observed the administration of medicines at 07:20 hours and at 11:00 hours. The administration of medicines was not in accordance with the policy/procedure or good practice guidelines. Areas of non compliance identified in Feb 2014 were still evident.

Medicinal products were not administered in accordance with the directions of the prescriber of the residents concerned as follows:
• Medicines were pre-dispensed prior to administering to residents.
• The administration times did not match the prescription times.
• Medicines were crushed but had not been prescribed to be taken in this way.

Systems to ensure residents' nutritional needs did not accord with the centres policy. Records showed that the majority of residents were weighed three to four times yearly and residents at risk of malnutrition were weighed monthly. Residents were risk assessed on admission and regularly thereafter. Nutritional care plans were in place that detailed residents’ individual food preferences, and outlined the recommendations of dieticians and speech and language therapists where appropriate. Some residents were on supplements which were prescribed and administered appropriately. Nutritional and fluid intake records were not in use. Information about dietary intake was reported in the daily nursing notes and verbally at shift handover meetings. Inspectors noted that the person in charge and nurse on duty enquired about the dietary intake of residents reported to have a poor appetite after each meal. They also assisted these residents to take supplements and drinks during the day. Records showed that residents who experienced weight loss gained weight. However the documentation of food intake required improvement and the menu had not been assessed by a dietician.

Inspectors tracked the care of a resident who had a percutaneous endoscopic gastrostomy (Peg tube) and found that the care plan directed the resident’s care in relation to the management of the tube, rest periods and the feeding regime. Weight records showed that the resident was maintaining a healthy weight.

Inspectors saw that there were 2 choices prepared for the lunchtime meal and residents in the dining room were verbally asked for their preference. However, for those residents who had communication difficulties the options were not presented to the residents so that an informed choice could be made.

The lunchtime meal in the dining room was a social occasion with attractive table settings and staff sat with residents while providing encouragement or assistance with the meal. However for those residents who remained in the communal sitting room to have their lunch this did not provide any different stimulation with regard to moving from one environment to another.

Judgment:
Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
The matter arising from the previous inspection related to improvements required in respect of restraint management.

Following the inspection the person in charge confirmed in writing that a restraint management policy had been reviewed and risk assessments carried out prior to the use of bedrails. This included the trial of alternative methods in consultation with a multidisciplinary team. It was further stated that a risk register was in place.

In total 5 residents were using integrated full length bedrails. Inspectors saw that other equipment/devices were used for example enabling bars to assist residents to move in bed, and in some instances these were used in conjunction with a single integrated bed rail. The bedrails had bumpers for protection and safety.

A resident who was the focus of the inspection and who was assessed as being at high risk of falls had bedrails in place and was being checked at least once in every 2 hours during the night. However, a restraint assessment had not been completed, the consent form in respect of bedrails had not been signed and a restraint care plan was not in place. This was not in accordance with the national policy.

On the day of the inspection in the main, all of the residents were up and about during the day and lap belts were used for some residents who were using wheelchairs. A resident who was the focus of the inspection and who was at risk of wandering had free access within the designated centre and could access the garden. Incidents where restraint was used were notified to the Authority in accordance with the regulation.

A recent photograph was not attached to the identification profile of a resident in the event of an unexplained absence of the resident.

There was a policy/procedure in place for the prevention, detection and response to abuse, however, this had not been updated to reference the National Policy ‘Safeguarding Vulnerable Persons at risk of Abuse’ (2015).

Currently there were no ongoing investigations, however, the provider/person in charge was knowledgeable of the investigation process.
Staff who spoke with inspectors were knowledgeable about the various types of abuse, recognising abuse, and were familiar with the reporting structures in place. An examination of the training records identified that not all staff had access to training in the protection of residents from abuse. In April and August 2014 sixteen staff attended training in the protection of residents from abuse. Twenty five staff worked in the designated centre.

There was a policy on behaviour management which emphasised “an environment that promotes well-being and has the least restrictions”. The references in respect of the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations were not current.

The guidance for staff promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD) and stated “it is critical to know about a person’s life story”, however, information had not been collected to document/compile a life story for individual residents.

Inspectors heard from staff that some resident's behaviour could be unpredictable/challenging, however, there was no validated assessment tool to assess these residents and the residents did not have a care plan. This was not in accordance with the designated centre's policy/procedure on behaviour management.

From discussions with staff and scrutiny of the training records provided staff had not participated in training regarding understanding and managing responsive behaviour. This was not in accordance with the designated centre's policy/procedure on behaviour management.

There was evidence that residents who exhibited behaviours that challenge had been reviewed by the GP and psychiatry of later life.

The inspectors reviewed the system in place to manage residents' money, and found that it was sufficiently comprehensive to ensure transparency and security.

Residents’ financial transaction records were signed and witnessed by two staff or a staff member and a resident and the monies held when checked corresponded with the resident's financial records.

Judgment:
Non Compliant - Moderate

Outcome 03: Residents’ Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

**Findings:**
Inspectors found that routines, practices and facilities did not maximise each residents' independence or choice.

The provider/person in charge identified in the action plan of the self-assessment questionnaire that an independent advocacy services would be available to facilitate residents with dementia and the completion date for this was identified as 30 June 2015. The provider/person in charge informed the inspectors that the representatives from an independent advocate service had visited the designated centre, however, a resident who communicated with the inspectors did not have knowledge of this and would have welcomed the assistance of an advocate.

There was evidence that residents were not involved in the consultation process and had not participated in the organisation of the centre. This was an area of non compliance in February 2014 after which the provider/person in charge stated that residents meetings would be held on a three monthly basis. Formal consultation with residents and their families has not taken place since 9 October 2015 from 14:00 hours to 14:30 hours. Thirteen residents were in attendance. Inspectors were informed that residents enjoyed the residents' meetings, however, prior to this the previous meetings were held on the 20 August 2014 and 7 April 2014. It is detailed in the statement of purpose which was reviewed on 24 April 2014 and submitted to the Authority that a planned residents' meeting “is organised once in 3 months to encourage residents to voice their suggestions in a group”.

Staff worked to ensure that residents received care in a dignified way that respected their privacy and were observed knocking on bedroom and bathroom doors prior to entering. However, bedroom doors had rectangular panes of glass from which it was possible to see into the residents’ bedrooms from the corridor. In addition residents did not have a key to lock their bedroom door. Inspectors did not see that residents were consulted regarding how they wished to spend their day.

Inspectors were informed that residents were able to receive visitors in private either in their own bedrooms or in the designated oratory. However, the oratory was not an appropriate place for private meetings and only 11 residents have single bedrooms. There were no restrictions on visitors. Inspectors saw that there was no current directory of visitors available and the last date of entry in visitors' book was 15 December 2015.

Residents were facilitated to exercise their civil, political rights during the current elections.

In the main, residents were satisfied with opportunities for religious practices as Mass was streamed from the local community chapel to the day room. Some residents from other denominations said that religious ministers visited the centre but their wish to attend services in their local community had never been discussed.

A record was not maintained for all residents of their valuables including residents’
personal property and clothing. The hanging space in the built-in wardrobes in some residents' bedrooms was insufficient for residents to store and maintain their clothes. Some residents’ clothing was stored in built-in wardrobes located in the corridor.

Inspectors noted that a meaningful activities assessment was carried out in respect of one of the residents who was the focus of the inspection. Information referenced that the resident sought interactions, engaged readily with others in activities and has good communication. In accordance with the care planning process following on from this a “resident activity level profile” should have been devised. However, this had not occurred. On the day of the inspection inspectors observed very little interaction with this resident.

For another resident who was the focus of the inspection a favourite activity highlighted that the resident enjoyed doing crosswords, however, the resident's condition had deteriorated to the extent that the resident was no longer able to be involved in this activity but the information had not been updated.

During the morning of the inspection the main activity was residents attending a streamed Mass from the local chapel, and following a short interval a prayer session was held. During lunch a DVD was played with suitable material to support a reminiscence activity. While residents enjoyed the DVD an opportunity to facilitate residents to discuss the material was missed.

Inspectors heard that residents did have activities such as music sessions and arts and crafts. There was evidence in the dining room that residents had been involved in making cards for St Patrick's Day, however inspectors did not see an activity schedule for the day. Residents were observed spending time watching television and having visitors in the late afternoon.

Care staff on duty did not engage residents in social and recreational activities and did not provide any stimulating activities on a one-to-one basis for residents with a cognitive impairment on the day of inspection. Communication took place when a care task was being undertaken.

There was little evidence that residents were actively supported to maintain connections with the local community. Some residents had mobile telephones and a handsfree phone was available. Residents did not have access to Skype. There was no evidence that trips or outings were organised events. A resident told inspectors that a wish to attend services in their local community had never been discussed.

There was no evidence of the use of memorabilia, artwork or homely furnishings to support residents to have a stimulating environment and recreational programme.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record the quality of interactions between staff and residents at five minute intervals, in the day room at various times and in the dining room at lunch time. The scores for the quality of interactions are:

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

The scores reflect the effect of the interactions on the majority of residents.

While there was evidence of positive connective care with individual residents, the overall experience for the majority of residents was neutral care for 58% of the two hour observation period. 38% of the time staff provided good quality task oriented care which mostly related to assisting with food or drinks.
+2 score was merited for 4% of the time as staff demonstrated positive connective care which benefited the majority of residents. Staff had sourced some DVDs which supported reminiscence therapy with residents. Seating in the day room did not support some residents to watch TV.
On the day of inspection TV viewing was overused to occupy residents with dementia.

**Judgment:**
Non Compliant - Major

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**Outcome 04: Complaints procedures**

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

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

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

There was a complaints policy and procedure. This detailed the process. The information was not publicised in the main hallway as it was face downwards on top of the suggestion box. However, inspectors were informed that a summary was available in the resident’s guide.

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

Residents who communicated with the inspectors were familiar with the provider/person
in charge, and could approach her with any concern or complaint.

There was a complaints log which recorded the complaints, investigation of the complaint and the outcome for the complainant. Inspectors reviewed the complaints records on file since the last inspection and found that details were maintained about each complaint, the investigation into the complaint and the action taken as a result of the complaint. In relation to the majority of complaints it was not documented if the complainant was satisfied with the outcome. The provider had not nominated a person who was not the complaints officer to ensure that complaints were appropriately responded to.

**Judgment:**
Non Compliant - Moderate

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<th><strong>Outcome 05: Suitable Staffing</strong></th>
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<tr>
<td><strong>Theme:</strong></td>
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<td>Workforce</td>
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**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The staffing skill mix is not adequate to meet the needs of residents. Staffing levels in the evening was an issue during the registration inspection in 2014.

Inspectors examined the duty roster for the day of the inspection. Staffing levels indicated the following:
- There was one nurse on duty from 08:00 hours to 1500, this nurse was the provider/person in charge. Later in the morning the matron, who was scheduled to be off that day came on duty to facilitate the inspection.
- A staff nurse was rostered to work from 14:00 hours to 20:00 hours.
- Three care assistants were on duty from 08:00 hours to 13:00 hours. This was reduced to 2 care assistants from 13:00 hours to 18:00 hours and further reduced to 1 care assistant from 18:00 hours to 20:00 hours.
- A nurse and one care assistant worked from 20:00 hours to 08:00 hours.
- A catering staff member works from 09:30 hours to 17:30 hours Monday to Saturday. On Sunday the staff member responsible for catering works from 09:30 hours to 14:30 hours.
- A cleaning staff member works 5 hours per day Monday to Friday and 4 hours each day of the weekend.

From 18:00 hours to 08:00 hours there is only a nurse and a care assistant on duty. This was an issue on the previous inspection. In response the provider stated that she based staffing levels on the dependency levels having a ration of 38% nurses and 61% care assistants. The rostered ratio on the day of inspection was 32% to 68% and this
included the person in charge.

The social needs of residents was not met. Care assistants were not involved in social activities and an activity coordinator was employed for only 4 hours in the week.

On Sundays no catering staff is rostered to make and serve the evening tea to residents which results in care staff carrying out this task depleting the provision of direct care to residents.

On each day of the week the catering staff member commences work at 09:30 hours and care staff make and serve breakfasts. Inspectors saw that night staff on duty prepared and served breakfast to residents and 14 residents who required assistance had their breakfast before the day staff came on duty at 8:00. The provider/person in charge and matron informed the inspectors that it was residents’ choice to have an early breakfast; however, this information was not detailed in the residents’ care plans.

The staffing arrangements did not provide at all times for supervision of residents in the communal room. There were insufficient staff nurses on duty to supervise the delivery of care.

Staff did not have up-to-date training and access to education and training to meet the needs of residents. Documentation in relation to staff training was poorly maintained and there was no system to ensure that all staff had mandatory training or other relevant training to care for residents with dementia. The action plan to provide dementia training to staff had not been progressed.

The following information was obtained from the training record given to the inspectors for examination:

• During two dates in February and March 2015 fire safety training was provided, however, not all staff had participated in this training.
• In June 2013 seven staff attended moving and handling training and on the 4 September 2015 nine staff accessed the training.
• On the 7 May 2015 seventeen staff attended training in relation to nutritional care.
• In April and August 2014 ten staff participated in infection-control training.
• On 6 May 2014 five staff received medication management training.

An entry in the training record identified that 7 staff attended MUST training, to assess residents for risk of malnutrition, however, the date of the training was not recorded and the content of training was not available.

An examination of randomly selected documentation in relation to staff working in the designated centre found that not all of the information identified in schedule 2 was available, for example Garda vetting and current registration details of nursing staff. The provider/person in charge informed the inspectors that documentary evidence in relation to this matter had not been retained in the designated centre.

There was evidence of good verbal communication between staff. Inspectors attended the handover meeting from night staff to day staff. This provided detailed information in relation to residents’ care and condition.
Formal staff meetings were held infrequently. This was as a result of staff shortages and the provider/person in charge working as a staff nurse in the centre. The last meeting was held on 2 October 2015 and 16 out of the total staffing compliment of 25 were in attendance. The agenda items included day-to-day operational matters for example staff were informed not to use toiletries belonging to other residents, insufficient storage space for residents' clothes and residents' clothing not labelled. The inspectors found the similar issues during this inspection.

The previous staff meeting was held on 24 September 2014.

Inspectors were informed that no volunteers currently work in the designated centre.

**Judgment:**
Non Compliant - Major

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

**Outstanding requirement(s) from previous inspection(s):**
This was the centre's first inspection by the Authority.

**Findings:**
The facility did not meet its stated purpose as a suitable environment to meet the needs of residents with dementia. The premises needed redecoration, storage space was limited and communal rooms and corridors were cluttered with equipment. Repair work was not carried out in a timely manner and there was no system to replace equipment which was no longer fit for purpose. Consideration had not been given to adaptations which would maximise the functioning of residents with dementia.

The provider had made some improvements to the physical environment in response to previous inspections including the conversion of the two existing bathrooms into wet rooms containing a shower. There were two assisted shower rooms this ratio did not meet the requirements of the Authority’s Standards. The matter had been raised on previous inspections but had not been satisfactorily addressed. The person in charge stated that she planned to address this by converting an existing store room into an accessible bathroom with toilet and bath. This work was due to be completed in June 2014. The bathroom was not operational because the bath was deemed to be unsuitable and the person in charge said she was waiting for the builders to install a suitable bath.

There was insufficient storage space in the designated centre for general equipment. Items for storage and disposal for example chairs, wheelchairs and an oxygen tank were found in the dining room, laundry room, in the corridors and in some residents' bedrooms.
Suitable storage facilities were not available for residents’ personal possessions. A lockable storage space and a secure facility for the safekeeping of residents’ personal money and valuables was available only in 1 resident's bedroom. Residents' bedrooms have built in wardrobes, however, the space for hanging clothing is limited and some residents’ clothing was stored in built in wardrobes/cupboards located in the corridor. Due to the lack of storage a resident's personal toiletries were stored on the floor.

Five low air-loss mattresses and a hoist had been purchased since the previous inspection. Maintenance records were not available to show that equipment was routinely serviced. For example the provider/ person in charge didn’t know when the weighing scales had been serviced as the servicing tag was missing. Many of the larger seats for more dependent residents were torn. This was a dignity issue and it presented an infection risk as the seats could not be properly cleaned. It was also a fire hazard because the filling which was exposed comprised flammable material. The timeframes for the plan discussed to reupholster the seating was unacceptable due to the risks involved.

The designated centre was not in a good state of repair as follows:

-There was evidence of leaks and dampness in some parts of the premises for example in the sluice room, corridor walls, the ceiling in the corridor outside a toilet facility, in twin bedroom and in the “gents toilet” and "ladies toilet”.
- The carpet in the front entrance hallway was worn.
- A number of overhead bed lights were not working.
- An electric socket for a resident alarm call system was not secured to the wall.
- There was no privacy lock on the recently established shower room.
- There is a resident's alarm call system in each of the bedrooms and the panel indicating which room the alarm has been activated in is located in the communal sitting room, however, the panel was not operating effectively as it does not display the light indicating the room.
- The medication trolley was rusted.

The communal space for residents included a large internal living room and a separate dining room. Most of the residents spent the day in the living room. The room was an internal room with velux windows. The area was congested and busy at times during the day and the noise levels were consistently high. The space available in the room did not facilitate any clustering of residents' seating and was arranged around the perimeter of the room. Inspectors noted that the adjacent dining room was not used, except by independent diners for dinner and tea. The lounge area at the front of the building was cool and used by residents in warmer weather. Residents did not have access to a room where they could meet visitors in private.

The centre was surrounded by amble grounds with lawns which had been maintained and a secure outdoor space which residents could access independently. There was some garden furniture provided.

There were seven twin bed rooms and eleven single bed rooms with wash hand basins but no en suite facilities.
All the rooms had profiling beds and the static pressure relieving mattresses used by 
two of the residents who were case tracked were found to have ‘bottomed out’ and 
were not fit for purpose. There was no evidence that equipment was serviced in 
accordance with the manufacturer's instructions for example glucose monitors.

The inspectors visited a number of bedrooms and found that they were bright, with a 
functioning call-bell system in place. The wardrobe space was also used for storage of 
continence pads and basins. An additional drawer unit was provided for residents. The 
paint on wall surfaces in some bedrooms and on window frames was chipped. The 
curtain on one bedroom window was hanging loose. The screening in shared bedrooms 
was satisfactory. Rooms were personalised with residents’ photographs, small items of 
furniture and soft toys. Inspectors discussed the significant improvements required to 
support residents with dementia. These included signage for residents to find their way 
around and to identify bathrooms, the lounge and their bedrooms. Flooring and the use 
of contrasting colours on walls and to identify bathrooms was also discussed. Externally 
their was no signage indicating the centre.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Safe care and support

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

**Findings:**
The matter arising from the previous inspection related to the risk management policy 
not being implemented as there were poor regular environmental safety checks and the 
health and safety statement was not up-to-date.

Inspectors found that the risk management policy had not been implemented. 
Inspectors saw a number of risks which had not been identified and assessed, for 
example, the hot water tap of a wash hand basin in a resident's bedroom was tested by 
inspectors and recorded a temperature of 49°C and a radiator temperature on the 
corridor located under a handrail near to the front entrance had a temperature of 48.5 
°C and did not have a radiator cover. These issues were areas of non compliance in Feb 
2014.

As a result of the hazards not being identified, measures and actions had not been taken 
to control the risks. 
Inspectors were informed of a medication error which occurred when a nurse omitted to 
administer a prescribed medicinal product. Inspectors found that the error had not been
documented. There was no evidence of an investigation into the medication error and no evidence of learning from the adverse event.

Freestanding radiators were available in the residents' bedrooms and in the entrance hallway, however, no risk assessment had been carried out.

Inspectors observed that the procedures, consistent with the standards for the prevention and control of healthcare associated infections was not maintained in the designated centre as the following were noted:
- The door to the sluice room was propped open using a commode pan even though there was a keypad lock on the door.
- A linen trolley stored both clean and dirty linen.
- There were no paper hand towels in a dispenser in a twin room and no distinction between the use of towelling hand towels.
- There were insufficient hand sanitisers throughout the designated centre and one of the hand sanitisers was obstructed from use by the storage of furniture.
- Arrangements for clinical waste were not appropriate as a clinical waste bin was stored beside the clean dressing trolley.

Inspectors found that adequate precautions had not been taken against the risk of fire as follows:
- Arrangements had not been put in place for the maintaining of all fire equipment, for example the date for the servicing of fire extinguishers had expired (January 2015).
- Evacuation of the designated centre in the event of fire would unnecessarily be delayed as curtains covered the fire exit doors.
- An evacuation route from a fire compartment was blocked as a spacious sitting chair was left on the corridor at 08:30 hours and the dining room fire door was wedged open.
- The procedures to be followed in the event of fire were displayed at a high level on the walls in the corridor and it was not possible to read one set of the procedures as the area was blocked by furniture.
- Adequate arrangements were not made for containing and extinguishing a fire as furniture stored in the corridor blocked the access to a fire extinguisher.
- Staff and as far as is reasonably practicable residents had not participated in simulated fire drills at suitable intervals including during the late evening/night time.
- Adequate arrangements had not been made for reviewing fire precautions as the laundry room (a high-risk area) stored flammable items and the door remained open throughout the inspection.

**Judgment:**
Non Compliant - Major

**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The matter from the previous inspection related to the ineffectiveness of management systems to monitor and improve the quality and safety of care to residents. Inspectors noted that improvements found in May 2014 had not been sustained and 13 of the 16 non compliances found in Feb 2014 were also found on this inspection.

Inspectors found that management systems were not in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. The person in charge carried out an audit on the 25 September 2015. The issues identified to be actioned were as follows:
• Sitting chairs to be refurbished.
• Leak in female toilet to be repaired.
• Shelves to be fitted in the shower room to store towels and toiletries.
• Disposal of wheelchairs which were not in use.

All of the above matters remained outstanding during this inspection, approximately 5 months from carrying out the audit.

It was also noted by the person in charge on this date that care plans were not up-to-date.

The provider/person in charge showed the inspectors a record whereby an audit in respect of medicines was carried out, however, there was no date on the record. The findings were as follows:
• The temperatures of the refrigerator for medicines had not been recorded.
• There was no photograph on a resident’s Kardex.
Inspectors found that an accurate record of refrigerator temperatures of medicines was not being maintained.

From discussions with the provider/person in charge, staff on duty, review of documentation and observation of practices it was evident that the designated centre did not have sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. See outcome 6 for details.

The provider/person in charge has initiated the recruitment procedures in order to fill a vacant full time nursing position and the possibility of a part time nursing position, however, to date this has proved unsuccessful.

As a result the provider/person in charge, primarily, is working as a staff nurse on duty. For example from Monday 15 February to Sunday 21 February 2016 the provider/person in charge worked 5 shifts in the designated centre as a staff nurse and was not rostered to perform the duties and responsibilities associated with the role of provider and person in charge.

Inspectors found that this resulted in ineffective management systems to monitor the
quality of care and experience of the residents on an ongoing basis.

An annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set out by the Authority had not been compiled in accordance with the regulation and made available for inspection.

Consultation with residents and their families had not taken place to inform the annual review.

**Judgment:**
Non Compliant - Major

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**Outcome 09: Statement of Purpose**

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The statement of purpose was reviewed by the provider/person in charge on the 24 April 2014.

It did not contain all of the information as per schedule 1 of the regulations as follows:
- The information set out in the certificate of registration.
- The criteria used for admission.
- A description (either in narrative form or a floor plan) of the rooms in the designated centre including the size and primary function.
- The total staffing compliment, in whole time equivalents, for the designated centre with the management and nursing compliments as required in regulations 14 and 15.
- The organisational structure of the designated centre did not detail the role of the director(s).
- Arrangements for the management of the designated centre if the provider/person in charge is absent from the centre.
- The fire precautions and associated emergency procedures in the designated centre.

Inspectors noted in the statement of purpose that “residents provide their own items” in respect of toiletries, however, inspectors saw in the shower room that staff used residents’ toiletries for common use.

Arrangements were not in place which respected the dignity of residents in accordance with the designated centre’s statement of purpose as detailed in Outcome 3.

**Judgment:**
Non Compliant - Moderate
**Outcome 12: Notification of Incidents**

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<tr>
<th><strong>Theme:</strong></th>
<th>Effective care and support</th>
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**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors found that a record of incidents occurring in the designated centre was maintained, however, all notifiable incidents were not notified to the Authority within the prescribed timescale. The Authority had not been notified that a resident, had a fall and sustained an injury which necessitated hospital treatment.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Siobhan Kennedy  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Consolation Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000079</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>23/02/2016</td>
</tr>
<tr>
<td>Date of response:</td>
<td>26/04/2016</td>
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Requirements

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

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

Outcome 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 policy in respect of monitoring and documentation of nutritional intake had not been fully implemented in respect of the following:

- Appropriate weighing of residents.
- Information regarding nutritional care plans was limited.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Menus had not been assessed/reviewed by the dietician.

There was no date on the nutritional assessment.

1. **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:**
a. All the staff informed about the importance to apply the policy and the residents will be weighed monthly or more often. The person in-charge will conduct an audit to ensure the residents are weighed at least once in a month. 23/04/16
b. Detailed information is now added to nutritional care plans. 23/04/16
c. The menu is given to a qualified dietician working with an authorised company (Abbott Nutrition) for assessment. Awaiting reply by 26/04/16.

**Proposed Timescale:** 26/04/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Care plans were not updated to reflect residents' changing needs or to include the amended/new care interventions following a review.

At the top of each care plan it stated “this care plan has been discussed/agreed and drawn up with the involvement of resident or significant other”, however, this had not been completed in respect of residents who were the focus of the inspection.

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

**Please state the actions you have taken or are planning to take:**
We are in the process of reviewing the care plans. Along with review the residents’ and the families are being consulted about their care plans.

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

**Theme:**
Safe care and support

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

In respect of a continence assessment it was deemed that no care plan was necessary, even though treatments and interventions were in place.

There was insufficient detail to guide staff in the care of residents with a urinary catheter.

Care planning documentation did not contain all of the relevant records as per the schedule, for example residents’ weights, referrals to allied health professionals specialist communication needs and a record of any medication error or adverse reaction in relation to each resident.

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

Please state the actions you have taken or are planning to take:

a. We have now reviewed the continence assessment of the particular resident and updated the care plan in consultation with the resident/family. 23/04/16

b. The particular resident’s care plan is updated now to guide the staff for the management of urinary catheter. Complete

c. We are in the process of reviewing the care plans and relevant records according to the Regulations which will be included in the care plan. 31/04/16.

Proposed Timescale: 30/04/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A resident who was the focus of the inspection did not have a seating referral.

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

Please state the actions you have taken or are planning to take:
A referral has been sent to the O.T. department to assess the seating for the particular resident. 23/04/16 referred. On the waiting list and will be followed up in 2 weeks.
### Proposed Timescale: 23/04/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Most of the residents were not consulted about their wishes and preferences for end of life care.

In the case of residents who had expressed their wishes and preferences, there was no evidence that the medical officer had been involved in the end of life discussions with the resident or that the residents' wishes would be respected in an emergency situation.

An assessment of residents' level of cognitive functioning was not routinely undertaken.

The assessment of a resident with macular degeneration was not explicit.

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

**Please state the actions you have taken or are planning to take:**
- a. We have now given the residents' and relatives documentations to complete in relation to their end of life care wishes and preferences. 23/04/16
- b. This will be liaised and consulted with the G.P. and will be documented in the end of life care documents. 31/05/16 (in line with next review by the G.P.)
- c. All the staff have been informed to review the resident's cognitive functioning along with the review of care plans. 15/05/16
- d. The resident with macular degeneration is routinely assessed by the optician and staff have been informed of the outcome of the assessment so that they can implement the treatment plan. 23/04/16

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### Proposed Timescale: 31/05/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents who had communication difficulties were not given an informed choice regarding meals.

#### 6. Action Required:
Under Regulation 18(1)(b) you are required to: Offer choice to each resident at
mealtimes.

**Please state the actions you have taken or are planning to take:**
Choice of meals will be displayed on the notice board and will be explained verbally to the residents at each meal time.

**Proposed Timescale:** 23/04/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no record of the medical, nursing and psychiatric (where appropriate) condition of the resident at the time of admission.

The name, address and telephone number of a resident’s next of kin or any person authorised to act on the resident’s behalf had not been updated.

A resident’s marital status was incorrect and had not been updated in the care planning records.

Some records were kept in such a manner that the documentation was not safe for example a discharge letter from an outpatient department was not secured into the care plan notes, some of the pages were loose in the ring binder and it was difficult to retrieve documents from the care plan folder due to the volume of documents/forms.

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

Pre assessment documentation was available for inspection. This was entitled “Initial Admission Assessment” however, there was no date or signature of admitting nurse.

A recent photograph was not attached to the identification profile of a resident in the event of an unexplained absence of the resident.

7. **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:**
a. A record of the medical, nursing and psychiatric (where appropriate) condition of the resident at the time of admission will be obtained for all future admissions. 23/04/16
b. The name, address and telephone number of residents’ next of kin are updated now. 23/04/16
c. All the details except the marital status were changed for the particular resident who lost her husband unexpectedly. All the staffs were informed about the change of her marital status and the change is made to the documents. 23/04/16
d. We are in the process of updating the care plans and old records will be removed from the care plans and will be kept in safe storage. Copy of CSAR will be obtained for all the future admissions under fair deal from hospital.
e. The person in charge will obtain a copy of The Common Summary Assessments (CSAR), from the hospital before accepting a new resident under fair deal scheme. 23/04/16
f. The nurses have been informed of the findings and advised to print their name and date while doing the initial admission assessment. 23/04/16
g. A photograph has been attached to the care plan of the resident in the event of an unexplained absence of the resident. 23/04/16

**Proposed Timescale:** 23/04/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The administration of medicines was not in accordance with the policy/procedure or good practice guidelines as follows:

Medicinal products were not administered in accordance with the directions of the prescriber of the residents concerned as follows:
- Medicines were pre-dispensed prior to administering to residents.
- The administration times did not match the prescription times.
- Medicines were crushed but had not been prescribed to be taken in this way.

The drug Kardex for residents who were tracked had been written in 2014 and erasing fluid had been used on two of the documents.

**8. 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:**
a. Extra staffing is facilitated to prevent any medication errors. An extra health care assistant is employed between 08.00-11.00am and 20.00-23.00 pm. 23/04/2016
b. We have requested a review by the particular resident’s G.P. to identify the best way and time to administer the medication to the resident without provoking the identified behavioural issues. It is decided in consultation with G.P. that to administer the medication within 1hr of prescribed time, and if the resident sleeping or agitated to report that in the comment column on the drug administration record. 23/04/16
c. G.P.’s were contacted and the resident’s whose medications are crushed is
The medications are reviewed three monthly and documented on the clinical folder. The drug Kardex which used erasing fluid has been re-written by the G.P. 23/04/16

**Proposed Timescale:** 23/04/2016

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Medicinal products had not been secured safely as medicines including eye drops were observed left in residents' bedrooms yet none of the residents self administer medicines.

The medicine trolley was left unlocked.

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

**Please state the actions you have taken or are planning to take:**
Assessment is done for self-administration of the particular medicine (Artificial tears) for the resident and the medicine is stored in a secure place.

The medicine trolley is kept locked all the time now.

**Proposed Timescale:** 23/04/2016

**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

The references in respect of the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations were incorrect regarding the policy on behaviour management.

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

**Please state the actions you have taken or are planning to take:**
The policy/procedures for the prevention, detection and response to abuse will be updated to include reference from the National Policy ‘Safeguarding Vulnerable Persons at risk of Abuse’ (2015).

The policy on behaviour management will be edited to correct the referencing.

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**Proposed Timescale:** 31/05/2015

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The guidance for staff in respect of the behaviours and psychological symptoms of dementia (BPSD) referenced a person’s life story”, however, information had not been collected to document/compile a life story for individual residents.

The designated centre's policy/procedure on behaviour management had not been implemented as there was no validated assessment tool to assess residents and residents did not have a care plan in respect of their behaviours which could be unpredictable/challenging.

**11. 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:**
a. The staff with the help of residents and relatives are in the process of compiling the life stories of residents who have dementia. Two life story books have been commenced. 30/05/16.
b. A validated assessment tool will be used to assess residents for behavioural issues. 15/04/16.
c. A care plan is in place for residents who have behaviours which could be unpredictable/challenging. 08/04/16

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**Proposed Timescale:**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff had not participated in training regarding understanding and managing responsive
behaviour. This was not in accordance with the designated centre’s policy/procedure on behaviour management.

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

Please state the actions you have taken or are planning to take:
Nine of the 25 staff had received training on management of behaviour that challenges. A training is arranged on 9th of June 2015 and all the remaining HCA and Staff Nurses in the nursing Home are facilitated to attend the course.

**Proposed Timescale:** 09/06/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Restraint practices were not in accordance with the national policy for a resident who was the focus of the inspection as a restraint assessment had not been completed, the consent form in respect of bedrails had not been signed and a restraint care plan was not in place.

13. **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:
The restraint assessment is in place now for the particular resident. The consent form which was signed by the G.P. and person in charge is now signed by the resident’s representative.

A restraint care plan is in place for the residents who uses side rails on the bed.

**Proposed Timescale:** 20/04/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The training records identified that not all staff had attended training in the protection of residents from abuse.
14. **Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
Staff training is arranged for the detection and prevention of and response to abuse on the 23rd of June for 15 staff members. Second session of the same course is arranged for the 12th of July and remaining staff will be facilitated to attend the course. Meanwhile a review will be given to all the staff during the handover along with the information leaflets about the protection of residents from abuse.

**Proposed Timescale:** 23/06/2016

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

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents did not have access to an independent advocacy service.

15. **Action Required:**
Under Regulation 09(3)(f) you are required to: Ensure that each resident has access to independent advocacy services.

**Please state the actions you have taken or are planning to take:**
Independent Advocacy service is available and information to all the residents and their families was provided in person and through the residents’ committee. A poster is in place for residents’ information and is included in the resident’s guide.

**Proposed Timescale:** 11/04/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were not consulted about or participated in the organisation of the designated centre.

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

**Please state the actions you have taken or are planning to take:**
A new resident's committee is formed. Residents and their relatives have volunteered to
take charge of the resident’s meeting and the person in charge or her representative will chair the meeting to enhance the consultation with residents.

**Proposed Timescale:** 01/04/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were unable to undertake personal activities in private as bedroom doors had rectangular panes of glass from which it was possible to see into the residents’ bedrooms from the corridor.

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

**Please state the actions you have taken or are planning to take:**
The rectangular panes on the bedroom doors are now obscured which prevents any observations of the resident once the door is closed.

**Proposed Timescale:** 11/04/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were not given an opportunity to exercise their choice with regard to having a key to lock their bedroom door.

Arrangements were not made for some residents who wish to attend religious services in the local community.

**18. Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**
The residents are now given a choice to have a key to their door and a duplicate key is kept in the nurse’s office.

The residents from different religious background are visited by their own religious leaders and their spiritual needs are met.

Arrangements are in place where a resident wishes to attend the religious services in
the local community are facilitated in consultation with the family.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Residents were not provided with opportunities to participate in activities in accordance with their interests and capacities.

Seating in the day room did not support residents to watch TV.

On the day of inspection TV viewing was overused to occupy residents with dementia.

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

Please state the actions you have taken or are planning to take:
Residents who are interested in watching T.V are seated facing the T.V.

We have employed another staff member to assist in providing meaningful activities to residents. This gives another 10hrs of direct activities with residents and these hours will be increased in consultation with the residents.

We provide activities such as bingo and exercise to music twice weekly and live music and dancing once weekly. Residents are given the opportunity to attend Mass once a week in the Nursing Home and Mass from the local church is streamed via T.V. daily.

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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
In the case of a resident who had difficulty communicating verbally, the care planning documentation did not contain a comprehensive communication plan which described the resident's non-verbal communication mode.

20. **Action Required:**
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.
**Please state the actions you have taken or are planning to take:**
A comprehensive communication plan is added to the care plans of residents who communicate nonverbally.

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

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

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The hanging space in the built-in wardrobes in some residents’ bedrooms was insufficient for residents to store and maintain their clothes.

Some residents’ clothing was stored in built in wardrobes located in the corridor.

Some residents' clothing was not labelled.

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

**Please state the actions you have taken or are planning to take:**
The residents are facilitated with chest of drawers along with built in wardrobes to store and maintain their clothing. Residents and families removed unused clothing.

All the residents' clothing are labelled now and the families are informed to label the new clothing and if not to ask assistance from the staff to label them.

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

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no current directory of visitors available and the last date of entry in visitors’ book was 15 December 2015.

A record was not maintained for all residents of their valuables including residents’ personal property and clothing.

22. **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:
A current directory of visitors is available now.

A record of residents valuables including residents’ personal property and clothing is in place.

Proposed Timescale: 24/02/2016

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 record of all complaints did not detail whether or not the resident/complainant was satisfied with the investigation and outcome.

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

Please state the actions you have taken or are planning to take:
The response of the resident/complainant to the outcome of the investigation of the complaint is now recorded in the complaints record.

Proposed Timescale: 04/04/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had not nominated a person who was not the compliants officer to ensure that complaints were appropriately responded to.

24. Action Required:
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:
The matron will act as a complaints officer and the person in charge will oversee that the complaints are appropriately responded to.
Proposed Timescale: 04/04/2016

**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The staffing skill mix is not adequate to meet the needs of residents. Staffing levels in the evening was an issue during the registration inspection in 2014.

25. **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:
- Two additional health care assistants have been employed and work during the medication rounds and during the morning hours when peak activities are happening, that is between 08.00-11.00am and 20.00-23.00hrs. The PIC has observed the staff and the residents and found that residents are comfortable and their needs are met with the current staffing level in the evening.
- We have employed another staff to co-ordinate activities with the residents.

Proposed Timescale: 16/03/2016

**Theme:**
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
All staff had not attended mandatory training as set out in the report.

Planned training in dementia care was not provided.

26. **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:
Nine staff had attended a training session on management of later stage dementia needs and behaviour that challenges on 4th September 2015.

Further training is arranged for the 9th of June 2016 which will facilitate all the remaining staff to attend this mandatory training.
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised.

**Proposed Timescale:** 09/06/2016

**Theme:**
Workforce

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

Please state the actions you have taken or are planning to take:
We are in the process of recruiting new nurses so that the person in charge and experienced nurses will have the time to do more supervisory functions.
We have now joined Nursing Homes Ireland who is assisting with the recruitment of nursing staff and we are in contact with two other agencies. We interviewed two nurses but were not suitable for our Nursing Home.
Meanwhile our part time nurses are working full time.

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

**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 designated centre was not in a good state of repair.
- There was evidence of leaks and dampness in some parts of the premises for example on the walls and in the cupboard in the sluice room, corridor walls, the ceiling in the corridor outside a toilet facility, in twin bedroom and in the “gents toilet”.
- The carpet in the front entrance hallway was worn.
- A number of residents’ sitting room chairs were torn.
- A number of overhead bed lights were not working.
- An electric socket for a resident alarm call system was not secured to the wall.
- There was no privacy lock on the recently established shower room.
- There is a resident’s alarm call system in each of the bedrooms and the panel indicating which room the alarm has been activated in is located in the communal sitting room, however, the panel was not operating effectively as it does not display the light indicating the room.
- A suitable bath had not been installed in the bathroom.

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

Please state the actions you have taken or are planning to take:

a. The roof of the nursing home which is the cause of the dampness is in the process of repair at present. First phase of repair is completed, and is tested for leaks and found leak proof on 26/04/16. The work is on the final phase now. 18/03/16 work started on and will be completed by 30/04/16.
b. A new carpet is in place now in the front hallway. 21/03/16.
c. The resident’s chairs were already on repair on rotation and is completed now. New chairs are ordered for residents’ rooms. 30/03/16.
d. All overhead bed lights are now working. 30/03/16.
e. All the needed electrical repairs are completed. 30/03/16.
f. Privacy locks are now installed in the new shower room. 30/03/16.
g. We are planning to modify the alarm system so that it will inform the room from which the call was made. 30/05/16.
h. Suitable bath is in place now and will be functioning after installing a call bell system in the bathroom. 30/05/16.

Proposed Timescale: 30/05/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Private accommodation for residents was in adequate as there was no designated visitor's room.

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

Please state the actions you have taken or are planning to take:
We are planning to construct a conservatory which will be used as visitors’ room for residents. Meanwhile residents have the options of using their own private room and the oratory. The dining room can also be used except during the meal times.

Proposed Timescale: 30/10/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient storage space in the designated centre as per schedule 6 3 (k).
The corridors was used for storing furniture which was not currently in use. The laundry room was used for storage of items. The dining room was used for storing chairs and other items of equipment. An unused oxygen tank remained on a windowsill in a residents’ twin bedroom.

Suitable storage facilities were not available for residents’ personal possessions as per schedule 6 3 (h)

A lockable storage space and a secure facility for the safekeeping of residents’ personal money and valuables was not available for the majority of residents.

There are built in wardrobes, however, the space for hanging clothing is limited and some residents’ clothing was stored in built in wardrobes/cupboards located in the corridor.

Due to the lack of storage a resident’s personal toiletries were stored on the floor.

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

Please state the actions you have taken or are planning to take:
a. The items which are currently not in use are removed from the nursing home. 14/03/16.
b. The oxygen tank which is needed in emergency for the particular resident is now kept in a cupboard outside the resident’s room and staff are informed of this change. 14/03/16
c. The residents were consulted and a lockable storage space has been ordered for all residents. 31/05/16.

Proposed Timescale: 31/05/2016

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some equipment for use by residents was not in good working order as per schedule 6. 2.

The drug trolley was rusted.

Inspectors saw mattresses used by some residents who were at a high risk of high pressure sores were worn and not fit for purpose.

There was no evidence that equipment was serviced in accordance with the
manufacturer's instructions, for example, the glucose monitor, seating weighing scales, oxygen equipment.

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

**Please state the actions you have taken or are planning to take:**
- a. A new drug trolley is ordered and will be delivered within next 4 weeks. 15/05/16.
- b. The mattresses which were worn are replaced on the day after the inspection. 24/02/16
- c. New glucose monitors are made available for individual residents who has diabetics. 01/03/16
- d. Battery was charged and weighing scales are now working. External agencies have been contacted to service the weighing scale. 21/04/16
- e. Oxygen equipment was serviced on the 15th of October 2015 and will be serviced as required. 15/10/15

**Proposed Timescale:** 15/10/2015

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

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors found that the risk management policy had not been implemented as there were a number of risks which had not been identified and assessed as follows:

The hot water temperature of the wash hand basin in a resident's bedroom recorded a temperature of 49°C.

A radiator temperature on the corridor located under a handrail near to the front entrance had a temperature of 48.53°C and did not have a radiator cover.

Freestanding radiators were available in residents' bedrooms and in the entrance hallway, however, no risk assessment had been carried out.

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

**Please state the actions you have taken or are planning to take:**
a. The thermostat for the hot water has been re-adjusted. The hot water temperature in resident's bedrooms are checked every morning, but never recorded this high.
09/03/16.
b. Radiator covers will be put in place for the radiators on the corridors. 30/05/16
c. Some free standing radiators have been removed from the nursing home and the
remainder will be removed. 25/04/16

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

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Measures and actions had not been taken to control specified risks.

### 33. 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:
Measures and actions are in place now to control the specified risks.

**Proposed Timescale:** 18/04/2016

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that a medication error was documented and no evidence of learning from this adverse event.

### 34. Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
Corrective action report will be added to all the identified errors, the findings from the audits are always communicated to the persons involved. But the particular staff will be asked to fill the medication error report and will be kept in the resident's file.

**Proposed Timescale:** 27/04/2016

**Theme:**
Safe care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that the procedures, consistent with the standards for the prevention and control of healthcare associated infections was not maintained in the designated centre as the following were noted:
- The door to the sluice room was propped open using a commode pan even though there was a keypad lock on the door.
- A linen trolley stored both clean and dirty linen.
- There were no paper hand towels in a dispenser in a twin room and no distinction between the use of towelling hand towels.
- There were insufficient hand sanitisers throughout the designated centre and one of the hand sanitisers was obstructed from use by the storage of furniture.
- Arrangements for clinical waste were not appropriate as the clinical waste bin was stored beside the clean dressing trolley.

35. 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:
a. All the staff informed not to use this practice and are instructed to take corrective action immediately of such incidents. 24/02/16.
b. A new trolley is ordered which will have different sections for clean and dirty linen. 30/04/16.
c. The paper towels in the particular room is replaced, We have decided to keep the towels in the drawers of the particular resident. 30/03/16.
d. We have ordered more hand sanitisers to be fitted throughout the nursing home. The furniture which was obstructing the hand sanitiser has been removed. 30/04/16.
e. The clinical waste bin is removed from beside the dressing trolley, and all the staff informed of the change. 24/02/16

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:
Arrangements had not been put in place for the maintaining of all fire equipment, for example the date for the servicing of fire extinguishers had expired (January 2016).

36. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
The fire Extinguisher which was expired on January 2016 has been replaced.

**Proposed Timescale:** 24/02/2016  
**Theme:** Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Evacuation of the designated centre in the event of fire would unnecessarily be delayed as curtains covered the fire exit doors.

An evacuation route from a fire compartment was blocked as a spacious sitting chair was left on the corridor at 08:30 hours and the dining room fire door was wedged open.

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

Please state the actions you have taken or are planning to take:
- The curtains which was cause of obstruction is removed to prevent any obstruction during emergency evacuation. 20/04/16
- Evacuation routes from a fire compartment are not now blocked and fire doors are not wedged open. All the staff are informed about keeping the evacuation route clear. 24/02/16 and ongoing

**Proposed Timescale:** 24/04/2016  
**Theme:** Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The procedures to be followed in the event of fire were displayed at a high level on the walls in the corridor and it was not possible to read one set of the procedures as the area was blocked by furniture.

38. **Action Required:**
Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

Please state the actions you have taken or are planning to take:
The procedures to be followed in the event of fire are displayed at more suitable level now. The furniture which was blocking the display is removed to assist with ease of reading.
Proposed Timescale: 13/03/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements were not made for containing and extinguishing a fire as furniture stored in the corridor blocked the access to a fire extinguisher.

39. 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 furniture which was blocking the fire extinguisher is removed.

Proposed Timescale: 13/03/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff and as far as is reasonably practicable residents had not participated in simulated fire drills at suitable intervals including during the late evening/night time.

40. Action Required:
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
Fire drill was performed on the 22nd of April at 6.30pm with 3 staff and 7.30 am on 23rd of April involving two staff.

Proposed Timescale: 23/04/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements had not been made for reviewing fire precautions as the
laundry room (a high-risk area) stored flammable items and the door remained open throughout the inspection.

41. **Action Required:**
Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

**Please state the actions you have taken or are planning to take:**
The lock in the laundry door is repaired and is kept closed all the time now.

**Proposed Timescale:** 01/03/2016

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**Outcome 08: Governance and Management**

**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Management systems were not in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

42. **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:**
We have now joined Nursing Homes Ireland who will assist with the recruitment of nursing staff and we have in contact with two other agencies and interviewed two nurses but were not suitable for our Nursing Home. Meanwhile our part time nurses are taken full time duties so that the person in charge can resume her duties.

**Proposed Timescale:** 19/04/2016

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**Theme:**
Governance, Leadership and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The designated centre did not have sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

43. **Action Required:**
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.
Please state the actions you have taken or are planning to take:
We have now joined Nursing Homes Ireland who will assist with the recruitment of nursing staff and we are in contact with two other agencies and interviewed two nurses but were not suitable for our Nursing Home. Meanwhile our part time nurses are taken full time duties so that the person in charge can resume her duties. We have employed three new staff members, 2 health care assistants and a staff to assist with activities. To assist with the daily maintenance of the centre, we have employed a maintenance manager.

Proposed Timescale: 19/04/2016
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
An annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set out by the Authority had not been compiled in accordance with the regulation and made available for inspection.

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

Please state the actions you have taken or are planning to take:
We are on the process of compiling an annual review to identify the quality and safety of care delivered to residents in the nursing home.

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:
Consultation with residents and their families had not taken place in preparation of compiling the annual review.

45. Action Required:
Under Regulation 23(e) you are required to: Prepare the review referred to in regulation 23(1)(d) in consultation with residents and their families.

Please state the actions you have taken or are planning to take:
Consultation with the residents and their families are in progress now as part of compiling the annual review.

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

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**Outcome 09: Statement of Purpose**

**Theme:**
Governance, Leadership and Management

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

The statement of purpose relating to the designated centre did not contain all of the information as per schedule 1 of the regulations as follows:

- The information set out in the certificate of registration.
- The criteria used for admission.
- A description (either in narrative form or a floor plan) of the rooms in the designated centre including the size and primary function.
- The total staffing compliment, in whole time equivalents, for the designated centre with the management and nursing compliments as required in regulations 14 and 15.
- The organisational structure of the designated centre does not detail the role of director(s).
- Arrangements for the management of the designated centre if the provider/person in charge is absent from the centre.
- The fire precautions and associated emergency procedures in the designated centre.

Arrangements were not in place which respected the dignity of residents in accordance with the designated centre’s statement of purpose as follows:

Inspectors saw that large chairs were used for transporting immobile residents between their bedroom and communal areas and staff manoeuvred these chairs as residents were seated with their back to the staff member.

At 08:30 hours the vacuum cleaner was used on the floor in the corridor outside residents’ bedrooms where residents were sleeping.

Staff did not respect residents’ toiletries as outlined in the statement of purpose as these were used for communal use.

**Action Required:**

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Please state the actions you have taken or are planning to take:**

a. The Statement of purpose will be updated to comply with the regulations. 31/05/16.
b. An O.T. Assessment is requested to identify the best way of transporting these residents’ from the communal room to their bed room. Meanwhile the staff are...
instructed to manoeuvre the chair with two people, one staff facing the resident and one on the back and continue the proper explanation and assurance to the resident. On the waiting list for O.T. assessment.
c. The cleaner is instructed not to use the vacuum cleaner outside the resident’s room until the resident is awake and in agreement with the same. 25/02/16
d. The resident’s personal toiletries are labelled and are used only for the particular resident. If any resident in need of toiletries the nursing home provides the same while waiting on supply from the families. 25/02/2016

**Proposed Timescale:** 31/05/2016

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### Outcome 12: Notification of Incidents

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
All notifiable incidents were not notified to the Authority within the prescribed timescale.

**47. Action Required:**
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

**Please state the actions you have taken or are planning to take:**
This was an oversight by the PIC as the resident was kept in hospital only for observation.

A copy of the notification has been forwarded to the Authority along with this action plan.

**Proposed Timescale:** 25/04/2016