<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Blackrock Abbey Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000118</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Cockle Hill, Blackrock, Dundalk, Louth.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>042 932 1258</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:Helen@talbotgroup.ie">Helen@talbotgroup.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>Orkcalb Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Helen Murphy</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Sheila Doyle</td>
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<tr>
<td>Type of inspection:</td>
<td>Unannounced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>59</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

▪ to monitor compliance with regulations and standards
▪ to carry out thematic inspections in respect of specific outcomes
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>27 September 2016 09:30</td>
<td>27 September 2016 17:30</td>
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<tr>
<td>28 September 2016 09:30</td>
<td>28 September 2016 14:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 16: Residents' Rights, Dignity and Consultation</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 17: Residents' clothing and personal property and possessions</td>
<td>Non Compliant - Moderate</td>
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<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection

This inspection report sets out the findings of an unannounced inspection to assess ongoing compliance with the regulations and to follow-up on progress with completion of the action plan to address non-compliances with the regulations as found on the last Dementia Thematic inspection in July 2016. Inspectors also reviewed unsolicited information received by HIQA in relation to management and prevention of pressure ulcers in the centre. This information was substantiated on this inspection. There were 21 actions in the action plan from the last inspection in July 2016. Eight actions were satisfactorily completed. 10 actions were progressed and three action plans had not been addressed. Inspectors noted that the time line for completion of these 13 action plans had not expired. Inspectors found that the governance and management systems were not effective. This was the centre's fourth inspection since April 2014 and major non compliances were found on three of
Inspectors found that the improvements evidenced on previous inspections had not been sustained and many areas of non-compliance found on this inspection were repeated from previous inspections in 2014 and 2015.

Inspectors met with residents, relatives and staff members during the inspection. They observed care practices and interactions between staff and residents. Documentation such as care plans, medical records, medication documentation and staff training records and policies among other aspects of the service were reviewed.

The centre catered for residents with a range of complex needs. While the centre predominantly accommodates older persons, 18 of the 59 people residing in the centre on the day of inspection had an intellectual disability. The provider nominee told inspectors that new premises suited to the needs of residents with an intellectual disability was under construction on a site in the locality. Arrangements were in place for independent advocacy services to support the residents moving to the new premises.

A judgment of major non compliance found in relation to safeguarding on the previous inspection was also merited on this inspection. Failure to ensure residents were appropriately safeguarded from abuse was found to be in major non compliance with the regulations on the last inspection in July 2016. The provider was required to immediately address this finding and put improved safeguarding procedures in place for residents with responsive behaviours. On this inspection improvements were made but all residents did not have the necessary support plans and management strategies in place to guide a consistent person-centred approach by staff. Inspectors found additional evidence of the provider’s failure to appropriately safeguard residents on this inspection. This failure was regarding inadequate staff recruitment procedures which did not provide satisfactory assurances that residents were appropriately safeguarded. Fourteen staff did not have An Garda Siochana vetting procedures completed. HIQA sought assurances that immediate arrangements were put in place by the provider to ensure residents were protected at all times.

Some residents' healthcare needs were not comprehensively met and were not supported by robust documentation management procedures to inform care needs and provision. Improvements were also required to ensure preventative pressure ulcer management procedures in the centre reflected best practice professional standards. Improvements were required in relation to staff supervision and training to ensure staff were skilled to support residents and their families and to provide person-centred care. Activity co-ordination staff had been recently appointed and had commenced putting procedures in place to ensure residents activation needs were met with programmes that reflected their individual interests and capabilities.

These findings are discussed further in the body of the report and the action plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.
Outcome 02: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:
Governance, Leadership and Management

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

Findings:
Since the last inspection some actions have been taken to improve the governance and clinical management structures in the centre. However, the findings of this inspection indicated that significant improvements were required in relation to the governance and management of the centre. Inspectors held the view that the non compliances found on this inspection related to a failure to put robust management systems in place to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

The inspection history of non-compliance with the regulations and the provider's failure to bring the centre into sustained compliance with the legislation did not provide adequate assurances that residents' care and welfare needs were satisfactorily met.

The resident profile in the centre included 18 residents with a profound intellectual disability. The general manager advised inspectors that plans were underway to accommodate these residents in accommodation currently under construction with an estimated completion date for mid 2017. Plans to commence consultation with residents and their relatives regarding moving to the new facility were at an early stage. However the findings on this inspection did not provide assurances that the care and welfare needs of residents were adequately met in the interim. The provider/person in charge advised inspectors that independent advocacy services were scheduled to support residents during the consultation phase.

The provider representative was also the person in charge of the centre and reported to the board through the general manager. The provider representative/person in charge was monitoring the quality and safety of key clinical parameters. However this process did not effectively flag weaknesses or inform comprehensive improvement procedures as evidenced by the repeated non-compliances from previous inspections and other findings on this inspection including:
- incomplete care documentation records including care records, care plans, care
interventions and reviews
- absence of a robust resident data management system to comprehensively inform their care needs
- deficits in medication management
- incomplete staff recruitment procedures that placed residents at risk of abuse.
- arrangements for improved supervision of staff were not embedded and as such did not ensure residents' needs were comprehensively met
- incomplete mandatory staff training
- inconsistent access to psychology, psychiatry and dietician services.
These findings are discussed further throughout this report.

In response to the finding that 14 staff were not Garda Vetted, the provider was required to take immediate action to safeguard residents. The action which the provider proposed did not provide the required assurances to the Chief Inspector that residents were safeguarded. The provider attended a meeting with HIQA to discuss the the findings of this inspection and the governance and management of the centre.

**Judgment:**
Non Compliant - Major

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**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
The communication policy document required improvement to inform strategies to support communication with residents who had specific communication needs related to their medical diagnosis, such as dementia or intellectual disability. The medication management policy had been reviewed since the last inspection to include anticoagulant record templates used in the centre.

Improvements were required to ensure that residents' records contained current, accurate information. Inspectors found that the restraint register indicated that a resident was using bedrails on a daily basis even though this person was not resident in
the centre for the previous two months.

As found on the last inspection in July 2016, the centre was in the process of transitioning from paper-based documentation to a computerised resident documentation management system. The computerised data management system in the process of implementation was password protected to ensure residents' personal information was securely stored. However, inspectors found that management of residents' documentation required significant improvement to ensure it clearly informed residents' care needs. Many residents had two documentation records in progress and paper based records were very difficult to access.

A sample of staff files was reviewed by inspectors; some documentation as required by Schedule 2 of the regulations was not in place.

**Judgment:**
Non Compliant - Moderate

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**Outcome 07: Safeguarding and Safety**
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

**Theme:**
Safe care and support

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

**Findings:**
During the previous inspection in July 2016 safeguarding measures in place for some residents were found to be inadequate. Inspectors issued an immediate action plan requiring action to be taken to ensure all residents in the centre were appropriately safeguarded. The provider responded to HIQA advising a schedule of actions underway to meet all residents' safeguarding and safety needs. Inspectors found that there was an improvement in the care of two out of three residents with responsive behaviours. Additional staff were recruited since the last inspection in July 2016. However inspectors found that staff recruitment procedures did not safeguard residents due to an absence of completed An Garda Siochana vetting for 14 staff working with residents. The provider was advised by HIQA that this finding required immediate action to ensure residents were appropriately safeguarded at all times.

Inspectors found that appropriate risk assessments were not completed for residents using bedrails or lap-belts. This was also found on the previous inspection in July 2016.
There were insufficient records of safety checks being carried out when restraint was in use, as required under the national restraint guidelines. Inspectors were told that hourly checks were completed on all residents overnight. However the system in place was that the overnight checks for some residents were not commenced until 22:00hrs regardless of when the residents returned to bed. There was no documentary evidence that the use of bed rails was reviewed. Inspectors saw that no safety checks were completed when lap-belts were in use.

Inspectors found that in some cases behavioural support plans were not in place for residents who had episodes of responsive behaviours relating to their medical diagnosis. Inspectors noted that a Disability Distress Assessment tool had been completed for some residents. However in some cases this documentation had not been updated since July 2015. In addition inspectors noted minimal intervention from services such as psychology for residents with an intellectual disability.

Inspectors also found that a resident in the older person service who required PRN (as required) psychotropic medication on seven occasions since 01 August 2016 did not have a behavioural support plan in place and although a referral for had been made for a psychiatric review, there was no indication when this consultation would occur. Behaviour support plans in place for two residents in the older person service were not person-centred. However inspectors did note that in the majority of cases staff were familiar with possible triggers and interventions that might work to de-escalate individual residents' responsive behaviours. During the inspection, other than the issues discussed under Outcome 16, staff approached residents in a sensitive and appropriate manner and the residents responded positively to the techniques used.

Inspectors saw that some improvement was required to the management of residents’ monies to ensure sufficient safeguarding was in place. Inspectors saw that a supply of toiletries was purchased for residents with an intellectual disability and noted that these items were stored in a locked press. However, the system in place was that the cost was levied on all residents regardless of whether or not they used any toiletries. Otherwise the inspector saw that accurate records were maintained, transactions had double signatures and receipts were available as appropriate. External and internal audits were completed on a regular basis.

Judgment:
Non Compliant - Major

Outcome 09: Medication Management
Each resident is protected by the designated centre’s policies and procedures for medication management.

Theme:
Safe care and support

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
Inspectors found that improvement was required in administration of PRN (as required) medications to ensure that residents were sufficiently protected by safe medication management practices. For example some residents, because of their conditions, required certain medications which were prescribed. However there was no guidance available as to when they should be administered, when they could be repeated or what combination if any should be given. A protocol was in place for one resident; however inspectors noted that this did not correspond with the prescription in place.

Otherwise inspectors saw evidence of safe medication management practices. Inspectors read a sample of completed prescription and administration records and saw that they were in line with best practice guidelines. Since the last inspection in July 2016, medications requiring administration as a 'crushed' preparation was individually prescribed. A anticoagulant record sheet was included in the medication management policy and procedures were in place to ensure all out of date or unused medicines were removed from stock and returned to the pharmacy. No out of date medications were found in the medication trolleys on this inspection. All opened medication preparations were dated to ensure they were not administered outside the timeframes specified by manufacturers' guidelines. Written evidence was available that three-monthly reviews were carried out. Support and advice were available from the supplying pharmacy.

Medications that required strict control measures in line with misuse of drugs legislation were carefully managed and kept in a secure cabinet. A register of these medications was maintained in addition to appropriate checking records where the stock balance was checked and signed by two nurses at the change of each shift. The inspector checked the balances and found them to be correct.

A secure fridge was provided for medications that required specific temperature control. The temperature was within acceptable limits on the day of inspection and was monitored daily.

Judgment:
Non Compliant - Moderate

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

Findings:
There was an effective system in place to monitor and record accidents, incidents and
near misses and the person in charge maintained overview of this system. These records referenced review and sign-off by the person in charge in addition to recommendations to be implemented to prevent recurrence. For example, one of the incident records reviewed by inspectors recorded an action for implementation of a low level bed for a resident who fell. The inspectors observed that this action had been completed and the resident had no further fall incidents.

The person in charge maintained a log of incidents which required follow up to ensure that the required corrective action was implemented and learning took place. The person in charge was aware of the legal requirement to notify the Chief Inspector regarding incidents and accidents. Since the last inspection in July 2016, specified incidents as required had been notified to the Chief Inspector by the person in charge.

Judgment:
Compliant

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

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

Theme:
Effective care and support

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

**Findings:**
As found on the last two inspections in March 2015 and July 2016, improvement was required to ensure that each resident’s needs were comprehensibly documented in care plans that clearly directed care interventions. For example, mouth care for residents with dental care needs and residents with responsive behaviours. Several gaps were also noted in the care documentation and some care plans in place. Inspectors saw that efforts had been made to make residents’ care plans more person-centred and had been achieved for some residents in the older person service. However, care plans were written in the first tense for residents with an intellectual disability such as ‘I like’, ‘I want’ etc. In some cases the wording used was medical in nature. An example of this was - ‘I am at risk of aspiration’. This information was not person-centred in that it was not an accurate reflection of the voice or understanding of most of these residents with severe and profound intellectual disabilities. Staff spoken with were aware of the necessary interventions to meet residents’ care needs but this information was not documented and as such posed a risk to the continuity of their care. There was evidence of involvement of some families in residents' care on a day-to-day basis. However
significant improvement was required to ensure residents and their families were consulted with, in relation to care plan development and reviews thereafter.

Findings from inspectors' review of a sample of care plans for residents did not evidence that they were consistently reviewed to reflect the recommendations of various members of the multidisciplinary team. For example the inspector saw that a resident had been referred to a speech and language therapist (SALT). Specific recommendations were made regarding the type of food to be provided. However the care plan had not been updated to reflect this recommendation. Inspectors also noted that some residents were assessed as being at risk of malnutrition and had not been referred to a dietician as required by the policy in place. There was also inconsistent review of residents' falls risk assessments post incidents of fall. As discussed in outcome 7, there was minimal intervention from services such as psychology for residents with an intellectual disability and for a resident in the older person service who required PRN (as required) psychotropic medication on seven occasions since 01 August 2016. While not documented in care needs documentation, staff were supporting this resident with significant responsive behaviours on a 1:1 basis on the day of inspection. Although this resident was referred for review by the psychiatric services, there was no indication when this consultation would occur.

The inspectors reviewed residents' pressure area care management in response to information received by HIQA since the last inspection in July 2016. Inspectors found evidence that a resident receiving care in hospital had developed significant pressure related skin injuries in the centre prior to their transfer to hospital. There were two residents in the centre at the time of this inspection with pressure related skin injuries, one of which occurred in hospital prior to admission to the centre and the other developed in the centre. Inspectors found there were care procedures in place to prevent residents developing pressure related skin injuries. However, these procedures required significant improvement. Each resident had their risk of developing pressure ulcers assessed and reviewed on a four-monthly basis. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate risk of ulcers developing. However, inspectors found multiple gaps in resident night-time repositioning records. There was also an absence of evidence to confirm residents were supported to change their positions while seated in assistive wheelchairs during the day. The risk assessment tool in use did not inform comprehensive skin-injury prevention management plans. For example, a sample of residents’ records reviewed by inspectors indicated that they were assessed as being at 'high risk' and 'very high risk' of developing pressure related skin breakdown. Inspectors’ found that the pressure relieving mattresses in place were all set at the same air pressure. This was not recognised or corrected by staff to ensure the level of pressure relief reflected the needs of individual residents. Inspectors reviewed procedures in place for the management of residents' wounds and found that appropriate procedures were in place to inform treatment plans. However, topical skin barrier preparations used on areas of residents' skin at risk of pressure injury did not reflect evidence based nursing practice. The nutritional needs of residents with pressure ulcers were reviewed by a dietician and tissue viability specialist services were available and were consulted to support staff with management of pressure wounds that were deteriorating or slow to heal.

**Judgment:**
**Outcome 13: Complaints procedures**
The complaints of each resident, his/ her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

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

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

**Findings:**
Inspectors reviewed the complaints procedure and found it described in detail how to make a complaint, who to make the complaint to and the procedure that would be followed upon receipt of a complaint. However inspectors did not see any easy read version of the complaints procedure to assist residents with particular communication needs.

Inspectors noted that issues of dissatisfaction that were highlighted by residents were not recorded in the complaints log and as such, this finding did not evidence appropriate investigation and satisfactory resolution.

**Judgment:**
Non Compliant - Moderate

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**Outcome 14: End of Life Care**
Each resident receives care at the end of his/ her life which meets his/ her physical, emotional, social and spiritual needs and respects his/ her dignity and autonomy.

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

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

**Findings:**
Staff provided end-of-life care to residents with the support of their medical practitioner and community palliative care services as necessary. No resident was in receipt of palliative care services at the time of this inspection. A pain assessment tool for residents, including residents who were non-verbal was available to support their pain management. The action plan from the last inspection in July 2016 was not satisfactorily
completed. Findings on this inspection did not evidence that residents were given opportunity to discuss their preferred options for their 'end of life' care.

Residents had access to an oratory on the first floor. Single rooms were available for 'end of life' care and relatives were accommodated to stay overnight with residents at the 'end of life' stage of their lives. Staff outlined how residents' religious and cultural practices were facilitated. Members of the local clergy from the various religious faiths provided pastoral and spiritual support to residents. Inspectors observed that some staff were trained to administer subcutaneous fluids to treat dehydration in order to avoid unnecessary hospital admissions at this time.

**Judgment:**
Non Compliant - Moderate

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**Outcome 15: Food and Nutrition**
*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

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

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

**Findings:**
Inspectors found that improvement was required to ensure that residents' nutritional needs were met. Validated nutrition assessment tools were used to identify residents at risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Weights were also recorded on a monthly basis or more frequently if required. However, inspectors noted that some residents were assessed as being at risk of malnutrition and had not been referred to a dietician as required by the centre’s policy. This finding is actioned in outcome 11. The inspector noted that these residents were also receiving nutritional supplements. In addition, several gaps were noted in the documentation and care plans relating to nutrition. Residents’ food preferences and specific requirements for modified consistency diets were not consistently recorded for residents with an intellectual disability.

Inspectors saw that residents were appropriately supervised during mealtimes on both floors given the complex care needs of many residents. However an inspector noted that social interaction between staff and residents with an intellectual disability was very limited and in some cases it seemed that staff were rushing these residents to finish their meals. Inspectors saw that there were two choices prepared for the lunchtime meal and chicken was also available as an alternative option. Staff told an inspector that residents with an intellectual disability were verbally asked for their preference; however
inspectors did not observe this happening. An inspector saw that residents with an intellectual disability and communication difficulties were not presented with menu options so that an informed choice could be made. The menu was on display in a pictorial format in both dining rooms but not positioned where residents could see it. Inspectors also noted that residents on the ground floor were not asked if they would like salt or pepper or other condiments.

Drinking water and juices were provided for residents and snacks were available outside of meal times if required. Inspectors saw residents regularly getting drinks during the day.

There was a spacious dining room available on both floors. However as observed on the last inspection in July 2016, the dining room on the first floor was overcrowded. Meals were provided to residents in one sitting. There were also a number of residents who ate in the sitting rooms on the first floor at mealtimes. The provider/person in charge advised inspectors that this finding had been identified and plans in place to change the purpose of the centre would ensure all residents had access to adequate dining facilities when completed.

**Judgment:**
Non Compliant - Moderate

### Outcome 16: Residents' Rights, Dignity and Consultation

Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
A residents' committee was established for residents and inspectors spoke with the chairperson, who was also a resident in the centre. At the last inspection the provider/person in charge advised inspectors that residents' meetings would be scheduled on an increased frequency to ensure residents had a voice in decisions about their home and kept informed about the transition of some residents. The person in charge told inspectors that advocacy services were available for all residents in the centre and that they had agreed to be involved in the consultation process with residents and families about moving to new accommodation. However, there was limited evidence that residents with an intellectual disability were consulted with or facilitated to
meaningfully participate in the organisation of the centre. Residents had a section in their care plan that addressed their communication needs.

Inspectors found that the rights, privacy and dignity of some residents was not consistently promoted and their independent choices encouraged. For example, inspectors saw that some residents with an intellectual disability were brought to the dining room for breakfast. However, they were not fully dressed and had not been supported to brush their hair. Inspectors also heard a small minority of staff using language that was not age-appropriate when speaking with residents. This included ‘good boy’, ‘good girl’, etc. Inspectors heard a staff member mimicking the verbal sounds made by a resident who had an intellectual disability. Inspectors also saw that most residents were wearing track suit bottoms. There was nothing to indicate that this was their preferred form of dress. Inspectors saw that residents had a variety of alternative clothing available to them. Some residents' personal information referencing their specific care needs was displayed in their bedrooms. These findings did not reflect a high standard of person-centred care that respected residents' privacy and dignity.

Since the last inspection in July 2016, two staff were employed to co-ordinate residents' activation with provision of activities that reflected their interests and capabilities. Although at an early stage and not completed for most residents, arrangements were in place to complete residents' social/recreational assessments. The activity co-ordinator discussed her plans to develop individual activation programmes especially for residents with needs that required 1:1 support or small group activities. This was being done with the involvement of residents and their relatives where appropriate. Inspectors found the activity coordinator to be committed to ensuring residents were provided with meaningful activities to meet their interests and capabilities. Training was scheduled for activity staff in provision of a sensory based programme. Some residents’ activation needs could be best met by sensory activities, especially residents with specialist needs that impaired their concentration, dexterity and communication. Electronic locking systems on interconnecting internal doors had been deactivated to enable residents to freely access both floors in the centre. Residents on the first floor were also facilitated to access a safe garden area on this inspection. 11 residents from the older person service were accommodated on the ground floor on this inspection. With the removal of internal door locking systems, some of these residents could independently access the facilities on the first floor or return to their bedrooms during the day if they wished to do so. The provider/person in charge had identified that not all residents could independently access both floors and advised inspectors that actions underway to change the resident profile of the centre to an older person service would assist with addressing this situation.

Inspectors found that staff spoken with were knowledgeable regarding residents' likes, dislikes and needs. Mass and Church of Ireland services were celebrated regularly and eucharistic ministers visited weekly. The person in charge said that residents from all religious denominations were supported to practice their religious beliefs.

There were no restrictions on visitors and there were a number of areas in the centre on both floors, where residents could meet visitors in private. These areas were styled in a way that facilitated quiet rest or meeting with a small group of visitors. Residents on the first floor had access to a library where they could also enjoy refreshments with their
Outcome 17: Residents’ clothing and personal property and possessions
Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:
Person-centred care and support

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

Findings:
Inspectors found that the personal property belonging to some residents with an intellectual disability was not sufficiently safeguarded through appropriate record keeping. For example, there was no evidence that clothing lists were updated to include new items of clothing when staff assisted residents to buy new clothes.

Resident laundry services were now out-sourced. Inspectors noted from discussions with staff that missing laundry was an issue for residents with an intellectual disability. Yet there were no procedures in place to ensure that adequate systems were in place to protect the property of residents who were unable to voice their concerns.

There was adequate space for residents’ possessions including a small lockable space in their bedrooms.

Judgment:
Non Compliant - Moderate

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

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

Findings:
Inspectors found that the care and supervision of residents with responsive behaviours had improved since the last inspection. However supervision of staff practices did not ensure some care procedures and documentation were completed and person-centred dignified care was provided to residents at all times. Inspectors found that staff had participated in training and had improved access to education and training to meet the needs of some residents since the last inspection, However, some staff were not knowledgeable about providing care for residents with a diagnosis of intellectual disability in particular providing holistic person centred care. Although, two staff were appointed with exclusive responsibility for residents’ activity provision, their training needs in activation of residents with an intellectual disability and dementia were not met.

An induction program was in place for newly recruited staff members. Since the last inspection in July 2016, actions to ensure that there were sufficient numbers of staff had been progressed. There was now a clinical nurse manager rostered on each floor. Additional staff of various grades had also been recruited to fill vacant posts. This recruitment included an additional nurse manager to support the person in charge with guiding clinical practice, staff supervision and auditing procedures. This additional clinical nurse manager was completing induction to their role with the person in charge on the days of this inspection. An additional carer was employed each day from 12:00 hours to 21:00 hours to increase supervision of residents.

The person in charge stated she had completed appraisals for all staff in 2016, and a training needs analysis had been carried out to identify training requirements. While access to training had improved since the last inspection this action plan was not completed. Staff training records showed that 11 additional staff had received training in management of responsive behaviours and 10 staff had received training in care planning. Staff training in safeguarding vulnerable adults was scheduled in the days following the inspection. While there was a variety of training topics provided to support the professional development of staff, mandatory staff training requirements were not up to date. A number of staff required updating of training in safeguarding vulnerable residents and safe moving and handling procedures. The person in charge told inspectors that this training was now on schedule for completion in 2016. Although inspectors were told that implementation of the computerised data management system was supported with a training programme for staff, many staff spoken with were not familiar with the system. Inspectors also found that nursing staff caring for residents with an intellectual disability on the days of inspection had limited training in this area of practice.

Moving and handling was an issue on the previous inspection. Inspectors did not observe any unsafe moving and handling practices on this inspection.
An actual and planned roster was available for review by inspectors, with changes clearly indicated. Documentation provided to inspectors showed that all nursing staff had up-to-date registration with An Bord Altranais.

**Judgment:**
Non Compliant - Moderate

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Catherine Rose Connolly Gargan
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>Blackrock Abbey Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000118</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>27/09/2016</td>
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<tr>
<td>Date of response:</td>
<td>01/11/2016</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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The non compliances found on this inspection related indicate a failure to put in place appropriate management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored.

1. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
• A review of the Governance Framework implemented earlier this year is underway to ensure that the service provided is safe, appropriate, consistent and effectively monitored. – Proposed Timescale 30/11/16

• A complete quality review of care documentation commenced in September 2016. This includes –
  • Assessments
  • Care plans
  • Care interventions
  • Referrals as appropriate to other healthcare professionals. – Proposed Timescale 31/12/16

• The Talbot Groups most senior and experienced trainer at Director of Nursing level has been assigned to Blackrock Abbey two days per week for a period of three months commencing on 01/11/16 to deliver a comprehensive training programme to include mandatory and refresher training to all staff as required. This will also involve on the floor observation of practice and practical support and instruction. A training plan is being developed at present and will be in place by 01/11/16. – Proposed Timescale 31/01/17

• epicCare- computerised resident care management/data system is fully operational since Monday 17/10/16. This system will provide timely accurate information to inform the care needs of residents. - Completed
• Recruitment procedures have been revised to ensure Garda vetting procedures are satisfactorily completed before staff commence work. All staff working in Blackrock Abbey have now satisfactorily completed Garda vetting procedures and certificates are on file. – Completed

• The appointment of a Group Director of HR has taken place and a database of compliance with Garda vetting will be maintained and monitored by the HR Department.

• The appointment of the additional CNM to improve supervision took place in September 2016. This appointment has and will continue to improve supervision of staff. It will also relieve existing nursing staff of some of their administrative work load and thereby allow them to concentrate on the delivery and supervision of direct care to residents. Two vacancies at CNM level have also been filled to improve CNM cover and supervision. - Completed

Proposed Timescale: 31/01/2017

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

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The communication policy required improvement to inform strategies to support communication with residents who had specific communication needs related to their medical diagnosis.

2. **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:**
- We are updating our communication policy to include strategies to improve communication with residents who have specific communication needs related to their medical diagnosis, such as dementia and intellectual disability. Training on the revised policy will be provided to staff as part of the training programme which will commence on 01/11/16.

**Proposed Timescale:** 31/12/2016

**Theme:**
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Maintenance of residents' records required review to ensure they are accessible.

3. **Action Required:**
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

**Please state the actions you have taken or are planning to take:**
- A complete quality review of care documentation has commenced. This includes –
  - Assessments
  - Care plans
  - Care interventions
  - Referrals as appropriate to other healthcare professionals – Proposed Timescale 31/12/16

- epiCare- computerised resident care management/data system is fully operational since Monday 17/10/16. This system will provide timely accurate information including management reports in an accessible format. - Completed

**Proposed Timescale:** 31/12/2016
## Outcome 07: Safeguarding and Safety

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Appropriate risk assessments were not completed for residents using bedrails or lap-belts. In addition safety checks were not completed when this equipment was in use in line with national restraint guidelines.

### 4. 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 National policy on restraint is in use in Blackrock Abbey Nursing Home. A full review of the use of bed rails and lap belts has been completed. The review involved a critical review of each incidence of use of bed rails and lap belts to determine compliance with policy. A robust review system of bed rails and lap belts is now in place and will be supported by regular audits. The supporting policy and MDT clinical decision prescription process have been revised to ensure compliance with national policy and that the following are adequately provided for - safety checks when bed rails and lap belts are in use, commitment to least restrictive practice for shortest length of time, authorisation process, special precautions, risk of entrapment, consent, monitoring, review, audit, emergency use and duty of care.

**Proposed Timescale:** 01/11/2016

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staff recruitment procedures did not ensure residents were safeguarded due to an absence of completed An Garda Siochana vetting for 14 staff working with residents.

Improvement was required to the management of residents’ monies to ensure sufficient safeguarding was in place.

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

**Please state the actions you have taken or are planning to take:**
- Recruitment procedures have been revised to ensure Garda vetting procedures are satisfactorily completed before staff commence work. All staff working in Blackrock Abbey have now satisfactorily completed Garda vetting procedures and certificates are
on file.

- Revised procedures have been implemented to ensure that residents’ money is now recorded and accounted for an individual resident basis.

**Proposed Timescale:** 01/11/2016

**Outcome 09: Medication Management**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
No guidance was available for PRN (as required) psychotropic medication to inform when they should be administered, when they could be repeated or what combination if any should be given. A protocol in place for one resident did not correspond with the prescription in place.

6. **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 review of administration of psychotropic medication will be carried out to ensure that where used, it is in line with current national policy - Towards a Restraint Free Environment in Nursing Homes, and is administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by the pharmacist regarding the appropriate use of the product.

**Proposed Timescale:** 31/12/2016

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

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Care plans were not updated to incorporate recommendations from the MDT.

7. **Action Required:**
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).
Please state the actions you have taken or are planning to take:
- A complete quality review of care documentation has commenced. This includes –
  - Assessments,
  - Care plans
  - Care interventions
  - Referrals as appropriate to other healthcare professionals.

- In future all care plans will clearly document the appropriate interventions to give
effect to the recommendations of all members of the MDT. Care plan auditing will take
place no less frequently than four monthly to ensure recommendations by all members
of the MDT are incorporated into individual care plans.

**Proposed Timescale:** 31/12/2016

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
While assessments were carried out, care plans were not consistently developed to
address some residents' identified needs.

Care interventions were not sufficiently detailed to guide care.

8. **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 complete quality review of care documentation has commenced. This includes –
  - Assessments
  - Care plans
  - Care interventions
  - Referrals as appropriate to other healthcare professionals.

**Proposed Timescale:** 31/12/2016

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
While there was evidence of involvement of residents and their families in residents' care,
improvement was required to ensure they were consulted with in relation to care
plan development and reviews thereafter.
9. **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:**
- A new care plan document has been introduced to improve and record communication/engagement with residents’ and their family in relation to to care plan development and reviews thereafter. This document will be kept on individual residents’ charts.
- Arrangements are in place to ensure that reviews of care plans take place no less frequently than at four monthly intervals in consultation with the resident concerned and where appropriate the resident’s family.

**Proposed Timescale:** 31/12/2016

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Many care plans were not updated to inform residents' changing needs.

10. **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:**
- Arrangements are in place to ensure that reviews of care plans take place no less frequently than at four monthly intervals in consultation with the resident concerned and where appropriate the resident’s family.
- A complete quality review of care documentation has commenced. This includes –
  - Assessments,
  - Care plans
  - Care interventions
  - Referrals as appropriate to other healthcare professionals.
- In future all care plans will clearly document the appropriate interventions to support the changing needs of residents which will give effect to the recommendations of all members of the MDT. Regular care plan auditing will take place to ensure recommendations by all members of the MDT are incorporated into individual care plans.
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<th>Proposed Timescale: 31/12/2016</th>
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<td><strong>Theme:</strong> Effective care and support</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Preventative pressure ulcer management did not reflect a high standard of evidence based nursing practice.

11. **Action Required:**
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
- Following completion of an independent review in August 2016 of preventative pressure ulcer management a number of recommendations arising from the findings of the review have been implemented and incorporated into ongoing care in the management of pressure ulcers. – Completed

  - The products used in the management of pressure ulcers have been reviewed and a recommended skin barrier is now in use. - Completed

  - As soon as a suitable training/mentoring programme has been finalised, two nurses will be trained to be champions of best practice in the management of pressure ulcers. – Proposed Timescale 28/02/17

  - Pressure relieving mattresses are serviced on an annual basis and more frequently if required. Training will be provided to ensure that the pressure relieving mattresses in place are used in a manner that maximises the potential benefit for residents.

  - A complete quality review of care documentation has commenced. This includes the accuracy with which night time re-positioning records are completed.

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<td><strong>Theme:</strong> Effective care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Findings on this inspection confirmed that there was limited access for some residents to additional healthcare professional expertise

12. **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:

- Referrals to HSE services are made where necessary. While there are delays accessing some services from the HSE for new referrals e.g. Psychiatry, we will continue to attempt to access these services on a regular basis.

- Additional professional expertise provided by Blackrock Abbey Nursing Home to residents includes – Psychologist, Consultant Nutritionist/Dietician, Occupational Therapist, Physiotherapist and Speech & Language Therapist. Dedicated Psychology sessions have been put in place to support the residents with an intellectual disability to transition from Blackrock Abbey to houses in the local community.

Proposed Timescale: 01/11/2016

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Inspectors did not see an easy read version of the complaints procedure to assist residents with particular communication needs.

13. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

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

- The existing easy read version of complaints procedure on display will be reviewed to ensure that it maximises assistance for residents with particular communication needs. Additional copies will be displayed at prominent locations throughout the nursing home.

Proposed Timescale: 30/11/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' complaints were not recorded in the complaints log

14. 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:
- With immediate effect all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied will be recorded in the complaints register.

Proposed Timescale: 01/11/2016

Outcome 14: End of Life Care

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents were not given opportunity to discuss their preferred options for their 'end of life' care.

15. Action Required:
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

Please state the actions you have taken or are planning to take:
- All residents will be given the opportunity to discuss their preferred options for their 'end of life' care. This will be offered in a supportive manner so as to provide appropriate care and comfort to residents approaching end of life, which addresses their physical, emotional, social, psychological and spiritual needs. This engagement with residents will be clearly documented in the residents’ records.

- Where advanced directives are in place the signatures of all members of the multi-disciplinary team involved in the decision making process will be clearly documented.

- SAGE Advocacy Service/Third Age Advocacy Service has provided support to residents in Blackrock Abbey Nursing Home for a number of years and will be consulted to see what support it can provide if required.

Proposed Timescale: 31/12/2016

Outcome 15: Food and Nutrition

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement
There was limited evidence of choice provided to residents with an intellectual disability.

16. **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:**
- The pictures on our pictorial menu cards have been enhanced to ease communication of choice. – Completed
- The menu options on display to enhance communication with all residents are being revised. Proposed Timescale 30/11/16
- Training will be provided for staff on person centred care and the importance of offering choice to all residents. Proposed Timescale 30/11/16
- Training will also be provided to staff on how best to communicate with residents who have specific communication needs related to their diagnosis, such as intellectual disability. Proposed Timescale 31/12/16

**Proposed Timescale:** 31/12/2016

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

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An inspector noted that conversation by staff with residents with an intellectual disability was limited and in some cases it seemed that staff were rushing residents to finish their meals.

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

**Please state the actions you have taken or are planning to take:**
- Training will be provided for staff on person centred care and the importance of providing appropriate assistance at meal times. This will be supported by maximising the number of staff available to assist in the dining room.
- Training will also be provided to staff on how best to communicate with residents who have specific communication needs related to their diagnosis, such as intellectual disability.

**Proposed Timescale:** 31/12/2016
### Outcome 16: Residents' Rights, Dignity and Consultation

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was limited opportunity for residents who were highly dependent to participate in activities that met their individual interests and capabilities.

**18. 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:**  
- Two Activity Co-ordinators took up duty on 01/08/16. Currently a comprehensive assessment of all residents is being carried out to ensure residents have access to activities that meet their individual interests and capabilities. These assessments are being conducted by the activities co-ordinators who will develop individualised activity programmes. These programmes will include opportunities for 1:1 activities.

**Proposed Timescale:** 30/11/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The rights, privacy and dignity of some residents was not consistently supported.

Some residents' personal information referencing specific care needs was displayed in some residents' bedrooms.

**19. 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:**  
- Personal information referencing specific care needs such as manual handling instructions and chair positioning is now kept inside residents’ wardrobes.

- Arrangements are in place to ensure all residents are appropriately dressed and suitably groomed before going to the dining room for breakfast.

- Arrangements are in place to ensure that staff encourage residents to select clothes of their choice and to consider individual preferences, and identities when providing assistance to residents.
Proposed Timescale: 01/11/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was limited evidence that residents with intellectual disability needs were consulted with or facilitated to meaningfully participate in the organisation of the centre.

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

**Please state the actions you have taken or are planning to take:**
- We will engage with SAGE Advocacy Service to see how best to consult, facilitate and support residents with an intellectual disability to meaningfully participate in the organisation of the centre.

Proposed Timescale: 30/11/2016

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

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Inspectors heard a small minority of staff using language that was not age-appropriate when speaking with some residents.
A staff member mimicked the sounds made by a resident.

21. **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:**
- Staff have been instructed by the PIC on appropriate language to use when communicating with adults. - Completed

- Suitably qualified and experienced staff in the provision of care to residents with an intellectual disability attached to Talbot Group Disability Services will provide education and training for staff on providing holistic person centred care. Proposed Timescale: 31/12/16
- We are updating our communication policy to include strategies to improve communication with residents who have specific communication needs related to their medical diagnosis, such as an intellectual disability. Training on the revised policy will
be provided to staff as part of the training programme which will commence on 01/11/16. - Proposed Timescale: 30/11/16

- Psychology services recognise imitating as being appropriate in some circumstances when communicating with residents with communication difficulties. Notwithstanding this, inappropriate behaviour will not be tolerated and an investigation has commenced on foot of information received following the inspection which took place on 27th and 28th September 2016. – Proposed Timescale: 30/11/16

Proposed Timescale: 31/12/2016

Outcome 17: Residents’ clothing and personal property and possessions

Theme:
Person-centred care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors found that the personal property belonging to some residents with an intellectual disability was not sufficiently safeguarded through appropriate record keeping.

22. Action Required:
Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

Please state the actions you have taken or are planning to take:
• A complete review of personal property records will be completed for all residents to ensure that personal property is adequately safeguarded through appropriate record keeping. - Proposed Timescale: 30/11/16

• Revised procedures have been implemented to ensure that residents’ money is now recorded and accounted for an individual resident basis. - Completed

Proposed Timescale: 30/11/2016

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some staff were not fully knowledgeable about providing care for residents with a diagnosis of intellectual disability in particular providing holistic person centred care.

23. 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:**
- Suitably qualified and experienced staff in the provision of care to residents with an intellectual disability attached to Talbot Group Disability Services will provide education and training for staff on providing holistic person centred care.

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<th><strong>Proposed Timescale:</strong> 31/12/2016</th>
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<td><strong>Theme:</strong> Workforce</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A number of staff required training in protection of vulnerable residents, safe moving and handling procedures, activation of residents with an intellectual disability and dementia and training on use of the computerised resident documentation management system.

**24. 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:**
- The Talbot Groups most senior and experienced trainer at Director of Nursing level has been assigned to Blackrock Abbey two days per week for a period of three months commencing on 01/11/16 to deliver a comprehensive training programme to include mandatory and refresher training to all staff as required. This will also involve on the floor observation of practice and practical support and instruction. A training plan is being developed at present and will be in place by 01/11/16.

- Refresher training will be provided to all staff on the use of epiCare care management system.

- In addition to the above training, staff suitably qualified and experienced in the activation of residents with an intellectual disability and dementia will provide education and training for staff as required.

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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Supervision of some staff practices required improvement to ensure care procedures and documentation were completed and person-centred dignified care was provided to residents at all times.

25. **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:**
- The Talbot Groups most senior and experienced trainer at Director of Nursing level has been assigned to Blackrock Abbey two days per week for a period of three months commencing on 01/11/16 to deliver a comprehensive training programme to include mandatory and refresher training to all staff as required. This will also involve on the floor observation of practice and practical support and instruction. A training plan is being developed at present and will be in place by 01/11/16. – Proposed Timescale 31/01/17

- The appointment of the additional CNM to improve supervision is now complete. This appointment will improve supervision of staff. It will also relieve existing nursing staff of some of their administrative work load and thereby allow them to concentrate on the delivery and supervision of direct care to residents. Vacancies at CNM level have also been filled to improve CNM cover and supervision. - Completed

**Proposed Timescale:** 31/01/2017