

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	St Columban's Retirement Home
<b>Centre ID:</b>	OSV-0000166
<b>Centre address:</b>	Dalغان Park, Navan, Meath.
<b>Telephone number:</b>	046 909 8232
<b>Email address:</b>	sjbbrennan@gmail.com
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Maynooth Mission to China (Incorporated)
<b>Provider Nominee:</b>	Patrick Raleigh
<b>Lead inspector:</b>	Sonia McCague
<b>Support inspector(s):</b>	Catherine Connolly Gargan
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	30
<b>Number of vacancies on the date of inspection:</b>	4

## **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: 05 July 2016 08:40 To: 05 July 2016 20:00

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

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

**Summary of findings from this inspection**

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection also considered progress on the findings and actions required following the last inspection carried out on 15 and 16 April 2015. The centre did not have a dementia specific unit and at the time of inspection inspectors were informed by the person in charge there were four residents of the 30 that had a formal diagnosis of dementia.

On behalf of the provider, the person in charge had submitted a completed self assessment tool on dementia care to the Health Information and Quality Authority (HIQA) with relevant policies and procedures prior to the inspection. As part of the thematic inspection process, providers were invited to attend information seminars given by HIQA. The provider had assessed the compliance level of the centre through the self assessment tool (SAT) but the findings of inspectors did not accord with all the SAT judgments. The previous table outlines the self-assessment and the inspectors' rating for each outcome.

As part of the inspection the inspectors met and spoke with residents, visitors and staff members. The Inspectors observed practices and reviewed documentation such as care plans, medical records, clinical and operational audits, policies and procedures, and contracts of care. Staff files were not examined on this inspection.

Overall, improvement was found in many of the eight outcomes that improvements were required following the previous inspection 15 and 16 April 2015. The governance, management and safeguarding arrangements had improved. Systems had been put in place to bring about improvement in the documentation of clinical and operational records, and the process for the management of complaints.

Since the previous inspection an audit of the service by an independent person was carried out and an action plan had been completed to inform recommended changes and improvements. The professional services of an independent advisory group was also contracted over a 12 month period in order to support and provide guidance to management and staff on how to achieve the required actions following the previous inspection and bring about efficient, quality improvements. Actions had been addressed or progressed in response to the recommendations made. Staff training had been provided in areas identified with further training required. A review of policies was underway with the support of the external advisor and new recording practices and reporting arrangements were being introduced following consultation with staff.

Each resident was assessed prior to admission to ensure the service could meet their needs and to determine the suitability of the placement. Following admission, residents had a comprehensive assessment and care plans were in place to meet their assessed needs. The healthcare needs of residents were met to a high standard. Residents had access to medical and mental health services and a range of other allied healthcare services.

While significant improvement and progress was found, further action was required in areas such as meaningful, structured and interesting activities, exploration of alternative treatment to hospital outpatient arrangements, staff training, aspects of the premises, security, notifications and records.

These and other matters are discussed in the body of the report and outlined in the action plan at the end of this report for the provider and person in charge's response.

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

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

**Theme:**

Safe care and support

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

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

**Findings:**

This outcome sets out the inspection findings relating to assessments and care planning, access to healthcare, maintenance of records and policies available governing practice. The social care of residents with dementia is reported in Outcome 3.

The self assessment tool (SAT) completed on behalf of the provider was rated compliant in this outcome with some areas for improvement highlighted. The action plan outlined that care plans were updated regularly, policies were in place and medication was reviewed by the general practitioner (GP) and pharmacist three monthly. Staff training was also stated as an action in this plan that was ongoing.

Inspectors focused on the experience of residents with dementia and they tracked the journey prior to and from admission of four residents. They also reviewed specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medication management, end of life care and maintenance of records.

Arrangements were in place to support communications between the resident and their family, religious community, and or the acute hospital and the centre. The person in charge visited prospective residents prior to admission and many had transitioned from the adjoining St. Columban community home on site. Arrangements in place gave each resident and or their family an opportunity to meet in person with other residents and staff, to provide information about the centre and assess or determine if the service could adequately meet the needs of the resident.

An admission policy entitled 'resident introduction, assessment and care initiation' dated 22 September 2015 was reflected in practice. Residents' files held a copy of their hospital discharge letters (medical and nursing). However, the files of residents admitted under 'Fair deal' did not include a copy of the Common Summary Assessments (CSARS), which details assessments undertaken by professionals such as a geriatrician, a medical social worker and nurse. As a result an improvement required included accessing and requesting a copy of the CSARS for future prospective residents.

Residents had a comprehensive nursing assessment on admission. The assessment process involved the use of validated tools to assess each resident's dependency level, risk of malnutrition, falls and their skin integrity. An assessment of the level of cognitive impairment of residents admitted with a diagnosis of dementia was available and recorded. An assessment of resident's cognition using a validated tool formed part of the admission, follow up or review process undertaken.

Arrangements were in place to meet the health and nursing needs of residents with dementia. Access to allied healthcare professionals including physiotherapy, dietetic, speech and language, tissue viability, continence advisor, dental, ophthalmology and podiatry services were facilitated on a referral basis. Referral or access to occupational therapy (OT) was also available. Some resident's seating arrangements had been reviewed by an OT to determine the suitability of the equipment in use and promote independence.

Inspectors were informed that residents had access to mental health services and psychiatry of later life services. From the cases tracked it was evident that this service had been available.

Clinical observations such as blood pressure, pulse and weight were assessed on admission and as required thereafter. Functional assessments were carried out prior to and on admission of residents. A care plan was developed following admission based on the residents assessed needs. Care plans had improved since the previous inspection to include personal and identified needs and changing circumstances of residents. Overall the care plans reviewed contained sufficient information to guide the necessary care interventions and preferences of residents. Arrangements were in place to evaluate existing care plans routinely and within a four monthly basis. Evidence that residents and or family, where appropriate, participated in care plan review meetings at intervals was seen.

Staff provided end of life care to residents with the support of their GP, community palliative care services and their religious community. 'End of life' care plans were recorded in the sample reviewed that outlined residents' views or decisions made on their behalf regarding their medical, hospital or acute treatment. However, in the sample of care plans reviewed, residents preferences and wishes regarding their preferred setting for delivery of care and after care arrangements had not been completed with residents and or family in the records available. Inspectors were informed that information regarding the will and preference of all residents was archived and a record was in the possession of the provider within the main building on site. This information would be made available as requested or required.

Staff and residents outlined how daily religious and cultural practices were facilitated within the centre. There was a designated chapel within the centre where religious services were held daily. Inspectors were told that the library, bar, garden facilities, dining room, 'Chinese room' were residents reposed and a larger chapel onsite within the St. Columban's grounds was available to all residents and used by some.

Two residents had pressure ulcers and or wounds which were reviewed. Inspectors

tracked wound care for residents and found their care to be appropriately managed that included referral to and review by a vascular consultant, review and advice from a tissue viability specialist and dietic services to promote healing. Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions. Wound care training for nurses was completed 9 May 2015 and again completed by nurses and care staff 4 July 2016.

Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were facilitated and monitored. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. Referrals for review by a dietician and or speech and language therapist were prompted following assessment and reviews. Records of referrals were maintained as required.

Inspectors saw that a choice of meals was offered and available to residents. There was the system of communication between nursing and catering staff to support residents with special dietary requirements. Mealtimes in the dining rooms were social occasions with attractive table settings and staff sat with residents while providing encouragement or assistance with the meal. Some residents choose to dine in their own bedrooms, the main dining hall in the adjoining building where their community dined or out in the local town, and this was facilitated.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. A system was in place to highlight and communicate the risk rate to all staff. As the result, the low rate of falls and incidents was reported.

Systems were in place in relation to transfers and discharge of residents and hospital admissions. Inspectors examined the files of residents who were transferred to hospital from the centre and found that appropriate information about their health, medications and their needs in relation to activities of daily living were included in the nurse transfer letter.

Many residents were supported to attend hospital out-patient appointments (OPA). However, staff were not sufficiently informed regarding the treatment alternatives or possibility of home treatment that may avoid the necessity for residents to attend frequent weekly out-patient appointments. The frequency and duration of travel and treatment was negatively impacting on the quality of life of some.

Suitable arrangements by an appropriate health care professional to meet the needs of each resident was facilitated or maintained as required. Residents had access to a pharmacist and general practitioner (GP) of their choice and the majority opted for the services of the GP attending the centre routinely. Out-of-hour medical, on call and emergency services were also available. The staff training record showed that thirty one of the 34 staff had completed cardio pulmonary resuscitation training over three days (5, 10 and 12 February 2016).

Arrangements were described that involved the pharmacist, GP and person in charge or clinical nurse manager's participation in a four monthly medication review. However, some improvements were required based on the findings from this inspection.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. However, the policy required review, revision and implementation in relation to prescribing, administration, recording and review of medication to meet with professional or regulatory requirements. Inspectors found practices relating to faxed prescriptions required detailing in the policy and implementation in practice in accordance with professional standards. One resident had received medication for seven days based on a faxed prescription. This practice and the policy available did not sufficiently protect resident in relation to medication practices and procedures found in the sample of resident's records inspected. Variances were found between the prescribed time and administration time of medicines. This arrangement required review to ensure all medicines were administered in accordance with the directions of the prescriber.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Safe care and support

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

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

**Findings:**

The self assessment tool (SAT) completed on behalf of the provider was rated compliant in this outcome.

The safeguarding policy was under review and was to reflect the principles of the National Policy on 'Safeguarding Vulnerable Persons at risk of Abuse' (2014).

Training records provided indicated that 22 of 34 staff members had training on the prevention, detection and response to abuse entitled 'elder abuse' in February 2016. The response to the previous inspection included that training in relation to elder abuse was also provided 3 April 2015, however this training was not reflected for 12 staff in the record submitted 26 July 2016 following this inspection. Further training was required to ensure training gaps were addressed to include all of the 34 staff working in the centre.

Staff who spoke with inspectors were knowledgeable about the various types of abuse, signs of abuse, and were familiar with the reporting structures in place. The Inspectors followed up on an allegation of abuse found on the last inspection and subsequently



notified to HIQA. Inspectors were informed the investigation was completed and the complaint matter was closed.

Measures were in place to ensure the safety of residents. The person in charge was well known to residents and visitors and staff confirmed that there were no barriers to raising issues of concern. However, inspectors read of the unexplained absence of a resident from the designated centre on two occasions that was not notified to HIQA, as required. A record of all incidents, where required, had not been maintained or notified to the Chief Inspector as required.

There were policies in place that included 'meeting the needs of residents with challenging behaviour' and 'aggression/violence/ self harm'. These policies described practices and procedures to guide staff, however, the systems and training referenced were not in place to support some aspects outlined. These policies required improvement to ensure they promote a positive approach to the behaviours and psychological symptoms of dementia (BPSD). In addition, training specific to dementia had not been completed by all relevant staff.

The training record summary/matrix provided and submitted 26 July 2016 indicated that 23 of the 34 staff had attended training 13 and 20 June 2015 in 'challenging behaviour' 'MAPA' which represents the management of actual or potential aggression (MAPA). The provider's response to the previous inspection included that training was provided 24 February 2015. However, this date was not included in the most recent training record received.

Some residents had responsive behaviours or behaviours that challenge, also known as behavioural and psychological signs of dementia (BPSD). Inspectors saw that assessments had been completed and used to inform interventions in residents' care plans, which were reviewed on an ongoing basis. Staff who spoke with inspectors were familiar with triggers and appropriate interventions to use. During the inspection staff approached residents with BPSD in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. There was evidence of interdisciplinary collaboration and person centered approaches with positive outcomes for residents.

Inspectors reviewed the use of restraint and found that six residents used bedrails. Inspectors noted risk assessments had been undertaken and were shown a new format for the assessment tool and decision to use restraint that was to be introduced into practice and reflected in the centre's policy. Staff spoken with confirmed the various alternatives that had been tried prior to the use of bedrails. Additional equipment such as low beds and sensor alarms were available and in use by some residents.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Person-centred care and support

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

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

**Findings:**

The self assessment tool (SAT) completed on behalf of the provider was rated compliant in this outcome.

Residents including those with dementia were consulted with and participated in the organisation of the centre. They were supported to make choices and be reasonably independent and to develop and sustain friendships. Residents in the main led purposeful lives, they decided how to spend their day and there were opportunities to participate in activities that suited their interests or former routine and ritual. However, improvement was required to introduce and develop interesting activities and opportunities for residents to learn new skills, activities and engage socially. The range of alternative or structured activities was not evident.

A culture of person centred care was evident and staff worked to ensure that each resident with dementia received care in a dignified way that respected their rights. Residents got up and retired to bed when they wanted to because this was their wish. Many had developed their own routine centred on the daily morning mass service, meal and prayer times.

Inspectors observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff were familiar with the religious ethos of the centre and knew the residents well, including their backgrounds and personal history. Residents had a secure internal courtyard with a sheltered seated area. However, the area was not well maintained and was not available for use. Weeds were seen in many parts of the flower beds and between patio area and bricked pathways in the secure courtyard. This area was not freely accessible during the on the day of inspection when the weather was sunny. This restriction had not been reviewed to ensure it did not negatively impact on residents' freedom and wishes.

Residents with dementia had supported access to surrounding landscaped gardens and fields. However, some pathways were in need of attention to avoid a slip hazard from the moss seen on them. Inspectors were informed that a change in the maintenance arrangements had recently occurred which had attributed to the environmental issues above. This required action is reported under premises.

External advocacy services were available to residents. Inspectors did not see any evidence of advocacy services being utilised for any resident.

Resident forums and meetings were available. Residents were satisfied that they were facilitated to exercise their civil, political and religious rights. All residents were male St. Columban missionary priests who were supported to practice their religion within their

community.

Residents confirmed that their rights were upheld. Staff sought the permission of the resident before undertaking any care task and they were consulted about how they wished to spend their day and care issues. Residents' rights to refuse treatments were respected. For example, some residents choose to dine at a time suitable to them and in a facility outside of the centre. A car for transportation arrangements was available to facilitate residents' needs, appointments and journeys on request. The bus route and stop was also available and accessible at the top of the lane. Arrangements were in place for residents to vote.

Friendships and support persons within the St. Columban community were formed to support residents. Resident groups met and members from their community visited daily to discuss current affairs and sports. The centre was described by the residents as an extension to their previous home that they shared with St. Columban priests.

There were no restrictions on visitors and there were a number of areas where residents could meet visitors in private apart from their bedroom. Some residents were active within their community and in the local community.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. The observations took place in the sitting room and area and in the dining room at lunch time. Observations of the quality of interactions between residents and staff for selected periods of time indicated that the majority of interactions demonstrated positive connective care. Overall, staff were observed to make eye contact, use touch and gentle encouragement in low key moderate and supportive manner. However, activity programmes were underdeveloped and opportunities for activities were not optimised even though inspectors observed many examples of positive interaction between staff and residents throughout the inspection. Residents had choices in how they planned and spent their day, however activities centred around religious ceremonies or prayer.

Inspectors observed that residents' choice was respected and control over their daily life was facilitated in terms of times of rising or returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. Inspectors observed that some residents were spending time in their own rooms, watching TV, or taking a nap. Other residents were seen to be spending time in the various communal areas of the centre. Newspapers and magazines were available as observed by inspectors. Activities beyond the daily religious routines and daily newspapers were mainly directed by the individual resident and unplanned. The exploration of meaningful activities other than religious activities was to be arranged and undertaken so that all residents including those with dementia were supported to engage in and benefit from other activities such as music, dance, sensory, pet and or 'Sonas Therapy' (a multidisciplinary programme).

One-to-one time was scheduled for some residents with dementia. However, staff engagement was seen to be more reactive than proactive at times. Inspectors were told that resident's life stories were to be captured by the completion of a new template 'a key to me' that was recently made available to staff. This template was to be

implemented to ensure each resident's interests and hobbies were documented to inform an activity plan going forward.

In addition, a record of residents' participation or level of engagement in activities were not recorded along with other aspects of care provision to demonstrate the service was meeting residents social needs. Dedicated activity staff did not form part of the staff team. Inspectors were informed by management staff of plans to recruit an activity staff this quarter to develop and promote the social care needs of residents.

The Communication policy available and dated 23 September 2015 required review. While it described operational communication systems in place to deliver care, it was not resident focused and did not provide sufficient information to guide staff in identifying, assessing and addressing the communication and sensory needs of residents. In addition, it did not include strategies to effectively communicate with residents who have dementia. Care plans were in place for those who had difficulty communicating, and many examples of positive connective care were observed throughout this inspection. However, further improvements by way of visual aids such as picture exchange communication systems (PECS) and the use of contrasting colour and textures within the centre was required. Residents had access to telephones and some had their own personal computer. Those with hearing impairment wore functioning hearing aids and attended audiology services to support their needs. Staff were aware of the individual needs of these residents.

As reported following the previous inspection, the contracts of care records reviewed did not reflect the requirements of the regulations to include the current arrangements, services in place and fees or charges applied. A limited amount of information was available within the contract of care and the arrangements in place to reflect the individual's source of funding, payment of monies or refund arrangements, and transactions to be undertaken by persons in accordance with the policy and audit guide regarding residents personal property and possessions, and as required by the Health Act 2007.

**Judgment:**

Non Compliant - Moderate

***Outcome 04: Complaints procedures***

**Theme:**

Person-centred care and support

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

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

**Findings:**

The self assessment tool (SAT) completed on behalf of the provider was rated compliant in this outcome.

A complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon.

A system and procedure was in place to detail investigations, responses and outcomes of complaints that was to be maintained in accordance with the centre's policy and as required within the regulations. The process included an appeals procedure.

The complaints procedure was displayed and met the regulatory requirements. Some residents and those relatives spoken to could tell inspectors who they would bring a complaint too. Inspectors were told there were no complaints made since the last inspection.

**Judgment:**

Compliant

***Outcome 05: Suitable Staffing***

**Theme:**

Workforce

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

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

**Findings:**

The self assessment tool (SAT) completed on behalf of the provider was rated substantially compliant in this outcome.

Staff including housekeeping, catering, and care staff were knowledgeable regarding resident's needs, likes and dislikes, and residents were complimentary of staff and expressed satisfaction with the care and services they provided.

Inspectors found that the number and skill mix of staff on duty and available to residents during inspection was sufficient to resident numbers and dependency levels and healthcare needs.

Staff actual and planned rosters were available and reflected the staffing provision on the day of inspection. Staff knew the residents well and were seen responding to their needs in a timely manner. Residents told inspectors they felt supported by staff that were available to them as required.

While there was adequate staff numbers and skill mix to meet the healthcare needs of residents, including residents with dementia, staff skilled to provide and promote interesting activities was required as previously referenced.

Since the last inspection many staff had received mandatory and relevant training to meet the needs of residents, however, as outlined in other outcomes, gaps in staff training provision were found that needed to be addressed. A programme of training was maintained and the record available showed that staff had received mandatory and relevant training in topics such as pressure ulcer prevention and wound management, fire safety training and the management of behaviours that challenge since the previous inspection. However, not all staff had received mandatory and relevant training as gaps in the training records were observed. This action remains outstanding from the previous inspection.

All staff were supervised on an appropriate basis. A recruitment and vetting process was described that was in line with best practice. Evidence of current professional registration for all rostered nurses was available. Recruitment procedures were described by new staff that were interviewed by inspectors. An induction procedure and supervision period for new staff was also confirmed as in place by staff and by the person in charge. A sample of staff files was not reviewed on this inspection.

Since the previous inspection the assistant director of nursing had retired. Inspectors were informed that this position was to be replaced by the recruitment of a clinical nurse manager (CNM) and that interview for this position was planned. Notification to HIQA was to be completed following the appointment of a CNM.

There were no volunteers engaged in the centre.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Effective care and support

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

No actions were required from the previous inspection.

**Findings:**

The self assessment tool (SAT) completed on behalf of the provider was rated compliant in this outcome.

The centre did not have a dementia specific unit and residents with dementia integrated with the other residents in the centre. The centre was found to be well maintained internally and it was warm, comfortably and visually clean. All internal walkways were clear and uncluttered to ensure resident safety when mobilising. The centre was bright with large windows that optimised natural lighting and view from each bedroom and the communal sitting room where residents mainly occupied.

Inspectors found that aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia. All resident accommodation was located on the ground floor. The centre has 34 single bedrooms with full en-suite facilities that were wheelchair accessible and comprised of a toilet, wash hand basin and shower. Adequate communal areas, supports and aids, along with kitchen, dining, sitting room and sanitary facilities were available to meet the needs and choices of the resident group. While bedrooms viewed by inspectors were personalised and had adequate storage and space to meet residents' needs. The doors and fittings in some bedroom areas were not in contrasting colours to sufficiently highlight en-suite areas or toilet facilities to promote independent access for residents with dementia.

Inspectors observed that the main sitting room and the adjoining seated area in the reception area were busy at times during the day but the noise levels were minimal. The communal sitting accommodation environment and corridors included familiar religious objects, domestic furnishing and homely features. There was some use of signage and colour cues to make areas more easily identifiable to residents with dementia. For example, bedroom doors were in a contrasting colour to floors and walls. Bedroom doors had the residents' name on them and a room number displayed but were all a similar colour. The option of improving signage and the use of contrasting colour throughout the centre required consideration in order to further support residents with dementia.

Peep-holes were located in residents' bedroom doors. Inspectors were told that they were seldom used, however, there was no evidence that they were closed off when not required. In addition there was no documented process to assess, monitor and support their use whilst minimising any impact on the privacy and dignity of individual residents. During the inspection a peep-hole was seen used by staff to view into a resident's bedroom. The person in charge was asked to review this facility immediately as it may compromise the privacy and dignity of residents.

Residents' accommodation was arranged into three areas, two were located around the entrance door off a wide corridor and one was located via a door operated by a switch. Some seating was provided along corridors for residents to rest if they wished. The entrance doors to one corridor where resident accommodation areas were was secured on the day of inspection and access required residents to co-ordinate pressing a switch to release the automatic lock device and to open the doors. This may negatively impact on residents' independent access around the centre. Beyond this secure door and the coded doors off the dining room there was open access to the upper floor and adjoining accommodation that did not form part of the centre. Therefore, the centre may not be suitable for all residents with dementia as parts of the centre were not sufficiently secure to promote independent mobility and safety throughout the centre's facilities. Inspectors read of the unexplained absence from the designated centre by a resident diagnosed with dementia on two occasions in 2016.

As previously mentioned, the external courtyard area containing pathways and shrubbery was provided but not accessible or well maintained. It was not available to residents during this inspection as the doors were secured.

Fire safety records and the fire register were not available on request by inspectors for inspection. The person in charge told inspectors it was mislaid. Both the person in charge and the provider nominee agreed to follow up and investigate this matter immediately.

**Judgment:**

Non Compliant - Moderate

***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:**

This outcome was not inspected in full. The action required from the previous inspection was followed up in relation to all staff had not received up to date training or experience in fire safety evacuation procedures at night.

This requirements was not completed. A record to demonstrated that all staff (day and night) had received training in fire safety and evacuation drills was not available.

**Judgment:**

Non Compliant - Moderate

***Outcome 08: Governance and Management***

**Theme:**

Governance, Leadership and Management

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

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

**Findings:**

This outcome was not inspected in full. The actions required from the previous inspection were followed up and improvement within the governance and management arrangements in the centre was found.

A clearly defined management structure was put in place, and the lines of authority and accountability to include persons external to the services undertaking specific roles and responsibilities related to care and welfare provision was co-ordinated by those



participating in the management of the centre and was to be clearly defined in a revised statement of purpose.

Since the previous inspection, arrangements were put in place and planned to support the person in charge. External agents were contracted to audit, review and improve the overall governance and management of the service. As a result, procedures and systems were put in place since the previous inspection that brought about improvements to deliver effective and consistent care in accordance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013.

A change in provider nominee as a person participating in the management of the centre had occurred since the last inspection on 1 May 2016. HIQA had been notified of this change. A satisfactory interview between the provider nominee and inspectors was carried during this inspection. He demonstrated sufficient knowledge and implementation of the legislation requirements and was aware of the statutory responsibilities. The Inspectors were satisfied that he was engaged in the governance, operational management and administration of the centre on a regular and consistent basis and had demonstrated a commitment to improving outcomes for the resident group.

The recruitment of a clinical nurse manager was ongoing at the time of this inspection to replace the other vacancy. HIQA is to be notified following the appointment of a new person participating in the management of the centre.

There was evidence of consultation with staff, residents and their representatives in relation to changes and developments ongoing related to the operation of centre.

**Judgment:**

Compliant

## 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:***

Sonia McCague  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	St Columban's Retirement Home
<b>Centre ID:</b>	OSV-0000166
<b>Date of inspection:</b>	05/07/2016
<b>Date of response:</b>	23/08/2016

### Requirements

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

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

### Outcome 01: Health and Social Care Needs

#### Theme:

Safe care and support

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

Operational policies relating to the prescribing and administration of medicines to residents required review and implementation to meet with professional or regulatory requirements.

Inspectors found practices relating to faxed prescriptions required detailing in the policy and implementation in practice in accordance with professional standards.

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

One resident had received medication for seven days based on a faxed prescription.

This practice and the policy available did not sufficiently protect residents in relation to medication practices and procedures found in the sample of resident's records inspected.

The admission policy required improvement to include accessing and requesting a copy of the CSARS for future prospective residents.

**1. 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:**

1. Medication policies relating to ordering, prescribing, storing and administration are currently being reviewed and updated in line with professional and regulatory requirements, and shall include updated practices regarding faxed prescriptions, as discussed and agreed with GP on the 6th of July 2016. This shall ensure the policy in place protects the residents, including in relation to the use of a faxed prescription (will be max. 72-hour use). Staff shall be educated on the updated policy.

2. An audit of medication management processes will be undertaken by the management team and pharmacy 4 weeks following the implementation of the policy (September 30th 2016). A system of ongoing medication audits has been put in place.

3. The admission policy will be updated to incorporate the inclusion of a copy of the CSARS as part of the admission details for residents going forward (this shall include the process for accessing and requesting a copy of the CSARS). (September 30th 2016).

4. A copy of CSARS will be requested/obtained from appropriate Health and Social Care Professionals prior to or on the resident's admission going forward. The importance of this document was discussed with GP on the 17th of August.

**Proposed Timescale:** 30/09/2016

**Theme:**

Safe care and support

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

Staff were not sufficiently informed regarding the treatment alternatives or possibility of home treatment that may avoid the necessity for a resident to attend frequent weekly out-patient appointments.

The frequency and duration of travel and treatment was negatively impacting on the

overall quality of life for some.

**2. 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:**

1. Alternative treatment was discussed with the resident, GP & Consultant at the external treatment centre July 2016. The resident, PIC & SN attended the Information and Assessment Meeting to determine resident's suitability for alternative treatment. They discussed the details of the implications of home treatment.

Following this meeting the resident approached the PIC and said he had made an informed decision that he would prefer for the time being to continue attendance at the unit.

A care plan is under development to minimise the impact of the appointments on the resident's quality of life. The attendance at the appointments will be reviewed at regular intervals going forward, as part of the resident's overall review.

2. Staff were educated regarding the treatment alternatives and possibility of home treatment for such residents, going forward.

**Proposed Timescale:** 23/08/2016

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Preferences and wishes regarding residents preferred setting for delivery of care and after care arrangements had not been completed with residents and or family in the sample of end of life care plans reviewed and available.

**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:**

1. End of Life Care Plans are currently being reviewed and updated for all residents. The review and update will incorporate the involvement of the resident and family, and will include all their preferences and wishes regarding end of life care (including delivery and setting) as well as after care arrangements. This will be part of the Quality Improvements being completed by the Provider Nominee.

**Proposed Timescale:** 18/11/2016

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

A copy of the Common Summary Assessments (CSARS) which details assessments undertaken by professionals such as a geriatrician, a medical social worker and nurse was not available in the sample of files reviewed of residents.

**4. 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:**

1. A full review of the pre-assessment practices will be completed by St. Columban's retirement home. The review will be completed by the PIC, CNM and an external company who specialise in quality and safety management systems. As per Action 1 above:

-The admission policy will be updated to incorporate the inclusion of a copy of the CSARS as part of the admission details for residents going forward (this shall include the process for accessing and requesting a copy of the CSARS). (September 30th 2016).

and

-A copy of CSARS will be requested/obtained from appropriate Health and Social Care Professionals prior to or on the Residents admission going forward. The importance of this document was discussed with GP.

**Proposed Timescale:** 30/09/2016

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

Variances were found between the prescribed time and administration time of medicines.

These arrangements required review to ensure all medicines were administered in accordance with the directions of the prescriber.

**5. 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:**

1. Education and Lessons learned have been provided to all nursing staff in relation to the finding of variances between prescribed time of administration and actual time of administration. As per Action 1 above, medication management processes are being reviewed in detail at present including the area of administration.
2. As per Action 1 a full audit of medication management will be completed, and these audits shall be repeated on an ongoing basis.
3. Lessons learned from the audits will be fed back to staff by PIC or CNM through the monthly Multidisciplinary Care Team Meetings.

**Proposed Timescale:** 30/09/2016

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

### **Theme:**

Safe care and support

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

The safeguarding policy was under review and was to reflect the principles of the National Policy on 'Safeguarding Vulnerable Persons at risk of Abuse' (2014).

There were policies in place that included 'meeting the needs of residents with challenging behaviour' and 'aggression/violence/ self harm'. These policies described practices and procedures to guide staff, however, the systems and training referenced were not in place to support some aspects outlined.

A new format for the assessment tool and decision to use restraint that was to be introduced into practice and reflected in the centre's policy.

Inspectors read of the unexplained absence of a resident from the designated centre on two occasions that was not notified to HIQA, as required.

### **6. 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:**

1. A new format assessment tool for the use of restraint has been introduced (Completed).
2. A restraint consent form, restraint register and an assessment tool are under development in line with policy and shall be implemented into practice. A comprehensive policy on the use of resident restraint is under development. This shall be approved and implemented by 14th October.
3. An audit on Restraint procedures will be completed following implementation of the new policies and procedures, and on an ongoing basis.
4. A policy on the Management of Behaviour that is Challenging and Behavioural and

Psychological Symptoms of Dementia is being developed and approved at present.

5. Training for all staff on these policies will take place following approval and activation of the policies.

6. The PIC has identified 11 staff who required immediate training in the area of positive behaviour support and management of the psychological symptoms of dementia. The training has been booked by the retirement home and will take place on two separate days to facilitate all care staff employed in the retirement home on the 20th and 28th of September.

7. The PIC is aware of the requirements of incident to be notified to HIQA and the timelines for same, and will notify HIQA immediately of any unexplained absence of a resident.

**Proposed Timescale:** 14/10/2016

**Theme:**

Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The policies in place that included 'meeting the needs of residents with challenging behaviour' and 'aggression/violence/ self harm' described practices and procedures to guide staff, however, the systems and training referenced were not in place to support some aspects outlined.

Gaps in staff training was found. The training record summary/matrix provided and submitted 26 July 2016 indicated that 23 of the 34 staff had attended training in 'challenging behaviour' the management of actual or potential aggression (MAPA) 13 and 20 June 2015 . The provider's response to the previous inspection action plan included that this training was provided 24 February 2015. However, this date was not included in the most recent training record received.

Training specific positive behaviour support and management of the psychological symptoms of dementia had not been completed by all relevant staff.

**7. 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:**

1. As per Action 6 above, the PIC has identified 11 staff who required immediate training in the area of positive behaviour support and management of the psychological symptoms of dementia. The training has been booked by the retirement home and will take place on two separate days to facilitate allcare staff on the 20th and 28th of September.
2. All staff shall also read, understand and acknowledge the policies in place for 'meeting the needs of residents with challenging behaviour' and 'aggression/violence/ self-harm'.

3. A review of the training matrix is taking place by the PIC (being updated at present). This shall also be reviewed regularly by the PIC to identify and highlight the training requirements of all staff.

**Proposed Timescale:** 14/10/2016

**Theme:**

Safe care and support

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

The training records showed that some staff had not attended training in detection, prevention of and response to abuse and the related policy was under review.

**8. 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:**

1. An elder abuse awareness week will be held in September to educate staff on all policies and procedures relating to challenging behaviour and prevention, detection of abuse and managing allegations of abuse.
2. All staff will have received training in detection, prevention of and response to abuse by October 14th 2016.
3. A review of the training matrix is taking place to ensure all training is kept up to date going forward.

**Proposed Timescale:** 14/10/2016

**Theme:**

Safe care and support

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

A record of all incidents, where required, had not been maintained or notified to the Chief Inspector as required.

**9. Action Required:**

Under Regulation 21(5) you are required to: Retain the records set out in paragraphs (7) and (8) of Schedule 4 for a period of not less than 7 years from the date of their making.

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

1. A new policy on incident reporting has being developed, approved and implemented into practice. (including staff education sessions).
2. The PIC is fully aware of the requirements of incident to be notified to HIQA and the timelines for same, and will notify HIQA appropriately in relation to any notifiable



events.

3. A record of all incidents that take place in the retirement home will be maintained and held in the retirement home for the required period of time.

**Proposed Timescale:** 23/08/2016

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

**Theme:**

Person-centred care and support

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

The Communication policy available and dated 23 September 2015 required review.

While it described operational communication systems in place to deliver care, it was not resident focused and did not provide sufficient information to guide staff in identifying, assessing and addressing the communication and sensory needs of residents.

The policy did not include strategies to effectively communicate with residents who have dementia.

**10. 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:**

1. A full review of the communication policies has been undertaken in line with regulatory and best practice requirements. Detailed policies on communication systems and techniques will be in place and approved by September 30th 2016.
2. Following the approval of the policy, staff will read, understand and acknowledge the policies and procedures. Staff education sessions on the policies will take place.

**Proposed Timescale:** 14/10/2016

**Theme:**

Person-centred care and support

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

Activities beyond the daily religious routines and daily newspapers were mainly directed by the individual resident and unplanned.

The exploration of meaningful activities was to be arranged and undertaken so that all residents including those with dementia were supported to engage in and benefit from other interesting activities.

**11. Action Required:**

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

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

1. The activities provided in the home are currently under review to include consideration of activities suitable for resident with dementia and to incorporate meaningful activities. Current activities for residents include music sessions with external entertainer, film nights, quiz time, board games, yoga and fit for life sessions.
2. Interviews for position of Activities Co-ordinator have commenced as part of the review of activities in the centre, in order to promote and enhance meaningful activities taking place for residents in the centre.
3. A resident survey on activities will be completed to incorporate resident input into the review of the activity program going forward, and this will be considering in the review of activities for the home.
4. An activity program will be developed and displayed monthly as part of the review of the activities in the home. In addition, all residents will have a completed individual activities plan based on their preferences.
5. The retirement home is purchasing an 'Enable Table', which facilitates wheelchairs and adapted chairs, to provide inclusion in various recreational activities and social opportunities.
6. Pet therapy organisations have been contacted and a request for services have been made.
7. A driver has been appointed, who will be available to bring residents on outings.

**Proposed Timescale:** 18/11/2016

**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 any evidence of advocacy services being utilised for any resident.

**12. 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:**

1. Sage advocacy services were contacted on the 17th of August. A meeting has been arranged for the Thursday the 25th of August. The representative will meet with the CNM and then with the residents.
2. Details of Sage advocacy services will be displayed throughout the retirement home.

**Proposed Timescale:** 31/08/2016

**Theme:**

Person-centred care and support

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

The use of a secure internal courtyard was restricted and had not been reviewed to ensure it did not negatively impact on residents' rights, freedom and wishes.

**13. 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:**

1. The use of the internal courtyard is no longer restricted. The courtyard area has been tidied, Gazebo painted and extra colourful flowers and plants added. Signage has been added, to encourage residents to spend time and avail of this facility. A barbecue was held on 4th August which was a great success, and another has been planned for September.

**Proposed Timescale:** 23/08/2016

**Theme:**

Person-centred care and support

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

A record of residents' participation or level of engagement in activities were not recorded along with other aspects of care provision to demonstrate the service was meeting residents social needs.

**14. 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:**

1. Activities care plans & assessment and implementation of 'Key to Me' profiles have commenced to record and reflect resident's choices.
2. As part of the review of activities, a record of residents' participation / engagement in activities will be introduced and recorded going forward.
3. As per Action 11, interviews for Activities Co-ordinators have commenced.

**Proposed Timescale:** 14/10/2016

**Theme:**

Person-centred care and support

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

As reported following the previous inspection, the contracts of care records reviewed did not reflect the requirements of the regulations to include the current arrangements, services in place and fees or charges applied.

A limited amount of information was available within the contract of care and the arrangements in place to reflect the individual's source of funding, payment of monies or refund arrangements, and transactions to be undertaken by persons in accordance with the policy and audit guide regarding residents personal property and possessions, and as required by the Health Act 2007.

**15. Action Required:**

Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

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

1. On the 10th of August a Meeting has taken place with the Bursar to clarify the source of funding.
2. A policy on the security of Residents' Accounts and Personal Property has been created and will be approved by the 30th of September 2016.
3. The Contract of Care template has been up-dated to reflect the requirements of the regulations to include the current arrangements, services in place and fees or charges applied (and is awaiting approval). The new contracts will be discussed and presented to all the residents by the Provider Nominee by the 18th of November 2016.
4. A full up-to-date inventory of resident's possessions will have completed by the 18th of November 2016.

**Proposed Timescale:** 18/11/2016

**Outcome 05: Suitable Staffing**

**Theme:**

Workforce

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

There was adequate staff numbers and skill mix to meet the healthcare needs of residents, including residents with dementia. However staff were not trained or competent to provide and promote interesting activities was required as referenced in outcome 3.

**16. 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:**

1. As per Action 11, interviews for an activity co-ordinator have commenced.

2. All staff will participate in the development of the resident's individual activities plan.
3. The activities program which will be introduced which will incorporate the needs of residents with dementia.

**Proposed Timescale:** 18/11/2016

**Theme:**  
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The training records showed that all staff had not received mandatory and relevant training. This action remains outstanding from the previous inspection.

**17. 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:**

1. Fire Training was completed on 27th of July 2016 and on the 8th of August 2016.
2. As per Action 7, the training matrix will be updated, and management will oversee the monitoring of mandatory training on an ongoing basis and address any outstanding training needs immediately.

**Proposed Timescale:** 31/08/2016

## **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:**

Inspectors found that aspects of the layout and design of the centre required improvement to meet its stated purpose in respect of providing accommodation for residents with dementia.

The doors and fittings in some bedroom areas were not in contrasting colours to sufficiently highlight en-suite areas or toilet facilities to promote independent access for residents with dementia.

Contrasting colours were not used to help resident to identify toilet and bathroom doors.

The option of improving signage and the use of contrasting colour throughout the centre required consideration in order to further support residents with dementia.

Peep-holes located in residents' bedroom doors required review and address. Inspectors were told that they were seldom used, however, there was no evidence that

they were closed off when not required.

Parts of the centre where resident accommodation areas were, had secured access that required residents to co-ordinate pressing a switch to release the automatic lock device and to open the doors. This may negatively impact on residents' independent access around the centre. Beyond this secure door and the coded doors off the dining room there was open access to the upper floor and adjoining accommodation that did not form part of the centre. Therefore, the centre may not be suitable for the needs of all residents with dementia as parts of the centre were not sufficiently secure to promote independent mobility and safety throughout its facilities. Inspectors read of the unexplained absence from the designated centre by a resident diagnosed with dementia on two occasions in 2016.

The internal courtyard area containing pathways and shrubbery was not accessible or well maintained. It was not available to residents during this inspection as the doors were secured.

**18. 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:**

1. Peep holes have now been covered and are no longer in use. Staff have been informed that they are no longer in use.
2. Signage & dementia specific aids are being sourced to promote independent access for residents with dementia and will be put in place.
3. Audits of door security being carried out & records being maintained.
4. One to one supervision provided to resident with Dementia, and external psychiatric assessment arranged for that resident 22/8/16.
5. Independent residents are all familiar and knowledgeable of how to safely access all areas of the retirement home.
6. As per Action 11, the courtyard is now accessible to all residents in the centre, and it has been refurbished and relaunched.
7. A review of the risks associated with access will be undertaken and recorded on the risk register.

**Proposed Timescale:** 18/11/2016

**Theme:**

Effective care and support

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

Fire safety records and the fire register were not available on request by inspector for inspection. The person in charge told inspectors the register was mislaid.

Both the person in charge and the provider nominee agreed to follow up and investigate this matter immediately.

**19. Action Required:**

Under Regulation 21(4) you are required to: Retain the records set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4 for a period of not less than 4 years from the date of their making.

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

1. A full investigation was carried out on the mislaid records. There have been lessons learned and preventative measures put in place.
2. Daily and weekly fire safety checks are now carried out and records retained.
3. A review of documentation and ongoing audit will be commenced.

**Proposed Timescale:** 23/08/2016

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

**Theme:**

Safe care and support

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

This requirements following the previous inspection was not completed.

A record to demonstrate that all staff (day and night) had received training in fire safety and evacuation drills was not available.

**20. Action Required:**

Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

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

1. Fire Training Completed is complete for all staff and training details will be available for inspection at all times.
2. All Personal Emergency Evacuation Plans will be reviewed and updated.
3. Emergency Evacuation plan for the Retirement Home will be put in place and approved and staff will be educated on the plan.
4. An Emergency box will be placed in a central area in the retirement home and all staff will be made aware of the location.
5. Risk registers will be reviewed in relation to risk of fire and all current controls will be listed.

**Proposed Timescale:** 14/10/2016