

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Abbeylands Nursing Home
Centre ID:	OSV-0000187
Centre address:	Carhoo, Kildorrery, Cork.
Telephone number:	022 25 090
Email address:	info@abbeylandsnursinghome.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Abbeylands Nursing Home & Alzheimer Unit Limited
Provider Nominee:	Kevin Regan
Lead inspector:	John Greaney
Support inspector(s):	Mairead Harrington
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	49
Number of vacancies on the date of inspection:	1

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
08 March 2016 08:50	08 March 2016 18:00
09 March 2016 09:30	09 March 2016 15:30

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

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

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 focus on the care and quality of life for residents with dementia living in the centre. Eighteen of the forty nine residents who were living in the centre on the days of the inspection had a diagnosis of dementia. Eleven of these residents were accommodated in a dementia specific unit.

The provider had submitted a completed self assessment on dementia care to the Authority with relevant policies and procedures prior to the inspection. The judgements from the self assessment and inspection findings are set out in the table above.

Overall, residents' healthcare and nursing needs were met to a high standard. Residents had access to medical, allied health and psychiatry of later life services. The management of complaints was fully compliant with regulations.

Some improvements, however, were required, particularly in relation to safeguarding practices. For example, suspicions or allegations of abuse were not always reported in a timely manner. In addition, the investigative process was not fully compliant with the centre's own policy and there was not always evidence of learning as a result of the investigation. While redecoration of parts of the centre was underway, including the painting of doors in the dementia specific unit, inspectors found that additional work was required. For example, there was a distinct lack of visual cues to support residents navigate to different parts of the centre and the dementia unit in particular lacked a homely feel.

There were systems in place to support residents with dementia and their representatives to participate in the assessments, care plans and the organisation of the centre. The centre had a stable workforce. Staff had comprehensive training, including training to work with people with dementia and behaviours that challenge.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of 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.

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 healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

Inspectors focused on the experience of residents with dementia and they tracked the journey of a number of residents with dementia.

There were systems in place to optimise communication between the resident/families, the acute hospital and the centre. The person in charge visited prospective residents in hospital prior to admission to make a determination on whether the centre could meet their needs. Prospective residents that were admitted from home were invited, with family members, to visit the centre and meet other residents and staff before making the decision to live there. The PIC also received a report from the resident's general practitioner (GP) detailing medical history and healthcare needs.

Residents' files held a copy of their hospital discharge letter and some of the files of residents admitted under 'Fair Deal' also held the Common Summary Assessment Report (CSAR), which detailed a comprehensive nursing assessment and, where relevant, assessments by other healthcare professionals. Inspectors examined a sample of records of residents who were transferred to hospital from the centre and found that appropriate information about their health, medications, and their specific communication needs were included with the transfer letter. There was also adequate information shared by the hospital with staff of the centre when the resident was discharged from acute care.

Residents' records contained comprehensive biographical details in a "Patient Information Sheet". This also included a brief overview of their medical history and interests/hobbies. A section entitled "This is Me" contained personal information such as what name the resident was usually addressed by, their previous living arrangements, hobbies, personal care needs and food likes/dislikes.

Residents had access to a GP of their choice, and to allied healthcare services including dietetics, physiotherapy, speech and language, chiropody and occupational therapy. GPs visited the centre regularly and records indicated that residents were reviewed on a regular basis. Out-of-hours GP services were also available. An organisation that provided physiotherapy services visited the centre on two afternoons each week providing group activity sessions and also provided one-to-one assessments when required. Dieticians and speech and language therapists from a nutritional company reviewed residents on a referral basis and there was evidence of good access. Occupational therapy services were also available on a referral basis. Dental and optician services were available from local providers and residents requiring ophthalmologist services, such as residents with diabetes, were seen in Cork University Hospital. A chiropodist visited the centre regularly.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed for issues identified on assessment. Improvements, however, were required in relation to the assessment and care planning process. For example, not all care plans were reviewed at a minimum of every four months and a number had not been reviewed for in excess of six months. Additionally, care plans did not always adequately address issues identified on assessment such as responsive behaviours. While there was evidence of the use of validated tools for recording episodes of responsive behaviour, there was no evidence that these records contributed to the development of care plans. In addition, care plans were not always developed detailing the communication needs of residents that had communication deficits, such as impaired verbal skills.

There were written policies and procedures in place for end-of-life care and for the management of residents' resuscitation status. Staff provided end of life care to residents with the support of their GP and the community palliative care team. Religious preferences were documented and there was evidence that they were facilitated. The centre had a chapel that was furnished to a high standard and was available to residents and family members. A specific "Resident Treatment Preferences" form was completed for residents to indicate the type of care they would like in the event of an acute illness ranging from transfer to hospital for full medical intervention to remaining in the nursing home for comfort measures only. Inspectors noted that for one resident this form had been signed by the residents next of kin and by nursing staff, however, the signature field for the GP was blank. Additionally, there was no record of the medical rationale supporting the decision. Approximately 50% of bedrooms were single rooms, so the option of a single room was usually available. Family and friends were facilitated to remain with the resident and there were adequate facilities for relatives to remain overnight.

There were a number of policies and procedures to guide practice in relation to the management of nutrition, including the provision of therapeutic and modified consistency diets, meals and mealtimes, and communication of dietary and nutrition information. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were assessed for the risk of malnutrition on admission and at regular intervals thereafter using a validated

tool. Residents' were weighed regularly. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on weight reducing, diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served.

Most residents had breakfasts in their bedrooms but had their lunch and supper in the dining rooms. There was one large dining room in the main part of the centre that could accommodate all of the residents living there and there was a smaller dining room in the Lee Suite. Breakfast was served for most residents from 08:00hrs, lunch was served from 13:00hrs and supper was served from 17:00hrs. Residents that chose to have their meals outside of these hours were facilitated to do so. Fluids were available throughout the day and tea/coffee and snacks were served at 10:30hrs and 15:00hrs.

On the day of the inspection there were adequate numbers of staff on duty to assist residents with their meals. Residents requiring assistance were assisted by staff in a respectful and dignified manner. Staff were seen to hold the hands of some residents in a comforting and reassuring manner.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Inspectors observed medication administration practice that was in compliance with relevant guidance. Some improvements, however, were required in relation to transcription practice. For example, nurses routinely transcribed prescriptions and these were usually signed by two nurses and by the GP. Of a sample of prescriptions reviewed by inspectors, one was not signed by two nurses and the medications on the PRN (as required) section were not signed by a GP. There were adequate systems in place for the return of unused and out-of-date medicines to the pharmacy. Medications requiring special control measure were management appropriately. Medications requiring refrigeration were stored appropriately and the fridge temperature was checked and recorded daily.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as moderate non-compliant.

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:

There was a policy in place that addressed prevention, detection, reporting and investigating allegations or suspicions of abuse. Even though the policy was reviewed in June 2015, there was no reference to the safeguarding of vulnerable adults policy to which all services that receive funding from the Health Service Executive (HSE) are obliged to comply.

While there were records available to demonstrate attendance at safeguarding training by staff, however, not all staff had attended this training. A sample of staff spoken with by inspectors were knowledgeable of what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about a colleagues behaviour. However, based on a review of records, where suspicions of abuse were raised, staff members did not always report these to line management in a timely manner. Additionally, while there was an investigation carried out in response to an allegation of abuse, inspectors were not satisfied that the investigative process was fully compliant with the centre's own policy on investigating allegations of abuse. Opportunities for learning as a result of the investigation were not availed of and there was insufficient evidence of changes to practice such as the development of a process to ensure that possible signs of abuse, including unexplained bruising, were reported/documented.

All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. Relatives of residents spoke highly of the care provided by the staff and their caring attitude.

There were policies in place about meeting the needs of residents with challenging behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. Training records reviewed by inspectors indicated that staff were facilitated attend training related to the care of people with dementia.

Records were maintained of triggers for particular behaviours, how the behaviour presented and consequences of the behaviour. There were care plans in place identifying how to support residents with responsive behaviour, however, there was insufficient evidence to demonstrate that they were updated based on up-to-date behaviour records. This action is addressed under Outcome 1. Staff spoken with were knowledgeable of individual residents behaviour including how to avoid the situation escalating.

There were residents who required the use of bed rails and risk assessments had been completed for these residents. The alternatives to bed rails had been considered, for example low beds. However, there was no restraint register and safety checks while restraints were in place were only intermittent and the frequency was not based on an individual determination of need.

Inspectors reviewed incident reports in relation to resident's behaviour and records confirmed the information given to inspectors that there were no recent significant behavioural related incidents.

There were adequate records in place on the management of residents finances.

This outcome was judged to be compliant in the self assessment, however, inspectors judged it as moderate non-compliant.

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:

Residents confirmed that their religious and civil rights were supported. The preferences of all religious denominations were respected and facilitated. There was a chapel available in the centre that was nicely decorated. Religious ceremonies were celebrated in the centre that included a weekly mass for Catholic residents, usually on Saturdays. Outside of religious ceremonies, the chapel was available as a quiet space for residents to pray and reflect.

Residents were facilitated to vote in local and national elections and the returning officer had visited the centre to facilitate residents to vote in the recent general election.

Contact details were available of an external advocate that was available to the residents. Inspectors were informed that there were no residents presently requiring the service.

There were residents meetings held in the centre, however they were held infrequently. Based on a review of records, meetings were scheduled to take place approximately every two to three months, however, the most recent resident's meeting was held in September 2015. There was also a survey of relatives completed in 2015. Inspectors were informed that issues raised through these forums were addressed, such as the rescheduling of tea times based on a request from residents. However, there was no action plan associated with residents forums/relatives surveys identifying who was responsible for implementing the actions or a timeframe within which they should be implemented.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. Residents chose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup. A number of residents were observed

having their hair done in the hairdressing salon on the day of inspection.

Residents had access to a number of private areas and rooms whereby they could meet with family and friends in private, or they could meet with them in their bedrooms. Approximately half of bedrooms were shared and there was adequate screening between beds to support privacy.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An overview of these observation periods is detailed below

Observations were recorded in the sitting room in the dementia unit and also in the sitting room of the main part of the centre. The total observation period was 115 minutes, which comprised one 30 minute period, one 40 minute period, and one 45 minute period. For rating purposes, there were 23 five minute observation periods. 18 scores of +2 were given predominantly when staff were seen to assist residents with their meals in the dining room of the dementia unit and when staff were sitting with residents in the sitting room of the main part of the centre. Staff were seen to sit with residents and chat with them while making good eye contact both in the dementia unit than in the main sitting room. Visitors were seen to come and go, and all were made welcome by staff and addressed by name. Five scores of +1 were given when there was one staff member in the sitting room of the dementia unit and there was minimal interaction with residents unless it was initiated by the resident. One score of 0 was given when there was no staff in the sitting room and residents were left without any stimulation.

Each resident had a "This is Me" completed which detailed residents interests and provided an overview of significant events in each resident's life. An activities co-ordinator was available in the centre each day from Monday to Friday. A range of activities were available each day such as card games, music and reading. There were also one-to-one activities for residents that do not participate in group activities. The activities co-ordinator was supported by another member of staff on Mondays and Tuesdays, when additional activities were available. Residents appeared to actively engage in the programme of activities that the activities staff appeared to be familiar with the individual communication needs of various residents.

Residents were seen to be wearing glasses and hearing aids, to meet their needs.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

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

Findings:

There was a system in place to ensure that the complaints of residents or their representatives were listened to and acted upon. There was a complaints policy that identified the person responsible for managing complaints and also included an appeals process. The complaints procedure was on prominent display in the centre, and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of management including the provider nominee, the person in charge, and clinical nurse manager. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints.

Inspectors viewed the complaints log that contained details of complaints, the investigation of each complaint, the outcome of the investigation and whether or not the complainant was satisfied with the outcome of the complaint.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as compliant.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

Inspectors found that staff delivered care in a timely and safe manner. During the inspection, residents were seen to receive attention from staff based on their care requirements.

Residents appeared to be familiar with staff. At meal times staff were seen to be speaking to residents, and where support to eat and drink was being provided, it was done in a discreet way. Where residents were able to eat independently they were supported to do so, for example, some residents had adapted equipment to help them hold items such as cups with handles.

An actual and planned roster was maintained in the centre with any changes clearly indicated. The person in charge was supported in her role by two clinical nurse managers, one of whom was on long-term leave. Inspectors reviewed staff rosters, which showed there was a nurse on duty at all times. There was a regular pattern of rostered care staff. The staffing complement included the activities coordinator, catering, housekeeping, administration and maintenance staff.

Residents and staff spoken with felt there were adequate levels of staff on duty. However, the provider and person in charge were requested to keep staffing under review as the needs of residents change. This was particularly relevant at night time when there was one nurse and three care assistants on duty for 49 residents. The person in charge stated that there was the option of bringing in an additional nurse at night time should the need arise.

There was a varied programme of training for staff. The training programme included training relevant to the care of people with dementia such as person centred dementia care, managing responsive behaviour, bone health and falls prevention, end of life care, restraint implications and consequences and safeguarding. Some improvements, however, were required in relation to training as not all members of staff had up-to-date training in fire safety, and a small number of staff did not have training in safeguarding or manual handling.

Inspectors reviewed a sample of staff files and found that some improvements were required. For example, there was not always a full employment history for all staff with satisfactory explanations for any gaps in employment.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as moderate non-compliant.

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:

Abbeylands Nursing Home is a purpose-built single storey residential centre with accommodation for 50 residents. The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable way. The centre is situated on large, well maintained grounds with ample parking facilities.

The centre was clean and spacious. Inspectors observed that all of the areas allowed for freedom of movement. All areas were bright and well lit, with lots of natural light in the day, and electric lighting when dark. Corridors had grab rails, and were seen to be clear of any obstructions. Residents were seen to be moving as they chose within the centre and the dementia unit allowed residents to walk freely around the corridor which was circular in design.

Resident' accommodation comprised 17 single and 16 twin-bedded rooms, all except one of which were en suite with shower, toilet and wash-hand basin. The remaining bed room was en suite with toilet and wash hand basin only. The centre was divided into three suites: Funchion suite (23 beds), Blackwater suite (14 beds), and the designated dementia unit, Lee suite (13 beds).

All bedrooms were spacious and some were seen to be personalised. It was observed that there was adequate room in the bedrooms for furniture including a bed, a chair and storage. The rooms also had enough space for equipment such as hoists to be used, with sufficient space to access the beds from either side. Some bedrooms were, however, in need of painting.

A process of redecoration of the dementia unit had commenced. On the days of the inspection the doors to the bedrooms in the dementia unit had recently been painted different colours to support residents identify their own rooms. However, significant work remained outstanding to make the unit homely and suitable for residents with dementia. For example, the unit, and the centre as a whole, lacked visual cues to support residents navigate to the various areas within the centre. The dementia unit in particular was in need of redecoration as there was evidence of scuff marks on walls and doors. There was minimal use of contrasting colours and there was a distinct absence of memorabilia or furniture to create a home like environment.

Communal space in the dementia unit comprised a sitting room and a dining room and there was also some comfortable seating along the corridors where residents could sit and rest. Residents in the dementia unit also had access to secure outdoor space.

Communal areas in the main part of the centre included a large reception area with comfortable seating, a large sitting room, a smaller sitting room called "The Library", a dining room, a smoking room, and arts and crafts/activities room and a chapel. There was a secure garden which was accessible from a number of doors along the corridor.

There were adequate sanitary facilities such as communal toilets and bathrooms and adequate sluicing facilities.

There was a large well-equipped kitchen with adequate hand hygiene and changing facilities for staff. There was evidence of good practice in relation to the management of

clinical and domestic waste.

There were up-to-date records of the maintenance of equipment such as beds, clinical equipment, speciality chairs and hoists.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as moderate non-compliant.

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:

John Greaney
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 report¹

Centre name:	Abbeylands Nursing Home
Centre ID:	OSV-0000187
Date of inspection:	08/03/2016
Date of response:	18/04/2016

Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

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

Improvements were required in relation to the assessment and care planning process. For example, not all care plans were reviewed at a minimum of every four months and a number had not been reviewed for in excess of six months.

1. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding

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

4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

We are currently updating our records and care plans and will have our care plans fully updated and revised by May 20th 2016

Proposed Timescale: 20/05/2016

Theme:

Safe care and support

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

Improvements, however were required in relation to the assessment and care planning process. For example, care plans did not always adequately address issues identified on assessment such as responsive behaviours. While there was evidence of the use of validated tools for recording episodes of responsive behaviour, there was no evidence that these records contributed to the development of care plans. In addition, care plans were not always developed detailing the communication needs of residents that had significant cognitive impairment.

2. 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:

We are currently updating our care plans and records to reflect the problem identification sheet being added to our resident care plans, we plan to have this complete by May 20th 2016.

Proposed Timescale: 20/05/2016

Theme:

Safe care and support

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

Inspectors noted that for one resident a treatment preferences form in relation to end of life had been signed by the resident's next of kin and by nursing staff, however, the signature field for the GP was blank. Additionally, there was no record of the medical rationale supporting the decision.

3. 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:

The decision referred to in your report was in fact reached by the Staff at the Hospital from which the Resident was discharged from, we have since sought clarity from the next of kin, we have as a result of this clarification had the GP sign the form on March 11th 2016

Proposed Timescale: 11/03/2016

Theme:

Safe care and support

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

Some improvements were required in relation to transcription practice. For example, nurses routinely transcribed prescriptions and these were usually signed by two nurses and by the GP. Of a sample of prescriptions reviewed by inspectors, one was not signed by two nurses and the medications on the PRN (as required) section were not signed by a GP.

4. 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:

This anomaly has been corrected and we will ensure this practice is not permitted, the correction was effected on March 11th 2016

Proposed Timescale: 11/03/2016

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:

There was a policy in place that addressed prevention, detection, reporting and investigating allegations or suspicion of abuse. Even though the policy was reviewed in June 2015, there was no reference to the safeguarding of vulnerable adults policy to which all services that receive funding from the Health Service Executive (HSE) are obliged to comply.

5. 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:

We are working on a new policy, this is being drafted and once approved will be implemented, distributed and discussed amongst the staff to ensure all staff members are aware of the changes to policy and of the Homes expectations in this regard.

Proposed Timescale: 20/05/2016**Theme:**

Safe care and support

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

There were residents who required the use of bed rails and risk assessments had been completed for these residents. The alternatives to bed rails had been considered for example low beds. However, there was no restraint register and safety checks while restraints were in place were only intermittent and the frequency was not based on an individual determination of need.

6. Action Required:

Under Regulation 07(3) you are required to: Ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.

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

We now have a register in place as required.

Proposed Timescale: 11/03/2016**Theme:**

Safe care and support

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

Improvements were required in relation to safeguarding practices, for example:

- based on a review of records, where suspicions of abuse were raised, staff members did not always report these to line management in a timely manner
- while there was an investigation carried out in response to an allegation of abuse, inspectors were not satisfied that the investigative process was fully compliant with the centre's own policy on investigating allegations of abuse
- opportunities for learning as a result of the investigation were not availed of and there

was insufficient evidence of changes to practice such as the development of a process to ensure that possible signs of abuse, including unexplained bruising, were reported/documented.

7. Action Required:

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

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

We have reviewed our policy in this regard, we propose to alter the policy to reflect some improvements we are keen to implement in this area. We have encouraged all members of staff to report any suspicions of abuse of any kind to the Nurse in Charge or any of the Management team at the Home, we propose to engage the services of a third party for more serious allegations of abuse and our revised policy will reflect such a change

Proposed Timescale: 20/05/2016

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:

There were residents meetings held in the centre, however:

- meetings were held infrequently
- there was no associated action plan to ensure that issues raised were addressed.

8. 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 hold residents meetings on a three monthly basis.

Proposed Timescale: 20/05/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

Not all members of staff had up-to-date training in:

- fire safety

- manual handling
- safeguarding.

9. Action Required:

Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

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

All new staff members will be fully trained in Fire Safety, Manual Handling and Safeguarding, we are in the process of devising new and improved training programmes for all staff members which will be running in the Month of June 2016. We will update our training matrix to ensure all staff members are fully trained and certified.

Proposed Timescale: 30/06/2016

Theme:

Workforce

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

Inspectors reviewed a sample of staff files and found that some improvements were required. For example, there was not always a full employment history for all staff with satisfactory explanations for any gaps in employment.

10. 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:

We have reviewed all files and have completed the employment gaps previously not recorded.

Proposed Timescale: 11/03/2016

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:

A process of redecoration of the dementia unit had commenced. On the days of the inspection the doors to the bedrooms in the dementia unit had recently been painted different colours to support residents identify their own rooms. However, significant work remained outstanding to make the unit homely and suitable for residents with dementia. For example:

- the unit, and the centre as a whole, lacked visual cues to support residents navigate to the various areas within the centre
- the dementia unit in particular was in need of redecoration as there was evidence of scuff marks on walls and doors
- there was minimal use of contrasting colours
- there was a distinct absence of memorabilia or furniture to create a home like environment
- a number of bedrooms needed redecoration.

11. Action Required:

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

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

We were in the middle of a complete refurbishment of the Lee suite at the time of the inspection a point acknowledged by the inspectors, it is difficult to understand how it is acknowledged that a schedule of refurbishment is recorded as having commenced and then a full list of works outstanding is recorded in the draft report, We did expressly advise the team that this work was underway. The matter of colours and a sense of homeliness within the home are subjective and we feel not appropriate in this context. We pride ourselves on our care provision and the environment we offer our residents, this is why we had a refurbishment programme underway at the time of the inspection, and We did not need direction from HIQA in this regard.

Proposed Timescale: 20/05/2016