

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Little Flower Nursing Home
<b>Centre ID:</b>	OSV-0000355
<b>Centre address:</b>	Labane, Ardrahan, Galway.
<b>Telephone number:</b>	091 635 449
<b>Email address:</b>	littleflower1@eircom.net
<b>Type of centre:</b>	A Nursing Home as per Health (Nursing Homes) Act 1990
<b>Registered provider:</b>	Bridgelynn Limited
<b>Provider Nominee:</b>	Joan Surman
<b>Lead inspector:</b>	Marie Matthews
<b>Support inspector(s):</b>	Geraldine Jolley
<b>Type of inspection</b>	Unannounced Dementia Care Thematic Inspections
<b>Number of residents on the date of inspection:</b>	43
<b>Number of vacancies on the date of inspection:</b>	7

## **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: 10 March 2016 10:30 To: 10 March 2016 21:00

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		Non Compliant - Moderate
Outcome 02: Safeguarding and Safety		Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation		Substantially Compliant
Outcome 04: Complaints procedures		Compliant
Outcome 05: Suitable Staffing		Substantially Compliant
Outcome 06: Safe and Suitable Premises		Non Compliant - Moderate

**Summary of findings from this inspection**

This report sets out the findings of an unannounced thematic inspection. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre. The inspection focused on six specific outcomes relevant to dementia care. Prior to the inspection the provider was asked to submit a completed self- assessment document by comparing the service provided with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland to the Authority along with relevant policies. The inspectors reviewed these documents prior to the inspection.

Inspectors met with residents, relatives, staff members and the person in charge. Inspectors tracked the journey of residents with dementia. They observed care practices and interactions between staff and residents. They used a formal recording tool for this. They also reviewed documentation such as care plans, medical records

and staff files. The inspection also considered information received by the Authority in the form of unsolicited receipt of information and notifications submitted.

The centre provides care for 50 residents requiring either long term, convalescent or a respite care. There were 7 vacancies on the day of the inspection. 11 residents were identified as having dementia and a further three were identified as having some level of cognitive impairment. There were policies and procedures in place around safeguarding residents from abuse. All staff had completed training, and were knowledgeable about the steps they must take if they witness, suspect or were informed of any abuse taking place. There were also policies and practices in place around managing responsive and psychological behaviour, and using methods of restraint in the service. Pre admission assessments were completed and residents' healthcare needs were generally met and doctors and allied support services visited regularly.

A total of six Outcomes were inspected. Five outcomes were judged as non-complaint. Non compliances identified related to ensuring CCTV did not impinge on residents' right to privacy, Improvements to premises for residents with dementia and to ensure safety, restraint management, care planning and assessment, mapping residents in their dementia journey and nutritional intake recording. The Action Plan at the end of this report identifies a small number of areas where improvements are required to comply 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.

**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):**

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

**Findings:**

The self assessment tool (SAT) completed by the provider for this outcome was rated substantially compliant. Inspectors identified areas where improvements were required.

There were 43 residents accommodated on the day of the inspection. Three residents were assessed as having maximum dependency needs; eight had high dependency needs, 11 had medium dependency and 21 were assessed as having low dependency needs. One resident was in hospital on the day of inspection. 11 residents were identified as having dementia and a further three were identified as having some level of cognitive impairment.

A comprehensive nursing assessment was completed for each resident on admission. The assessment process involved the use of validated tools to assess each resident's risk of falls, malnutrition, level of cognitive impairment and skin integrity. Inspectors saw that a care plan was developed within 48 hours of admission based on the residents assessed needs. The care plans contained the required information to guide the care of residents, and were updated routinely on a four monthly basis or to reflect the residents' changing care needs. There was documentary evidence that residents and relatives, where appropriate, had provided information to inform the assessments and the care plans. Staff nurses, health care assistants, residents and relatives who spoke with inspectors demonstrated appropriate levels of knowledge about care plans. There was evidence that residents were regularly reviewed and inspectors saw that this review included a review of their medication as well as any acute or chronic conditions suffered.

Where residents had been transferred from an acute hospital a copy of the hospital discharge letter was included on their file. An out-of-hours GP service was provided by these GPs. Residents could retain their own GP if they so wished. The inspector reviewed a sample of files and found that GPs reviewed residents on a regular basis.

A full range of other services was available including speech and language therapy (SALT), physiotherapy, occupational therapy (OT), dietetic services, tissue viability and psychiatry of later life. Chiropody and optical services were also provided. The inspector

reviewed residents' records and found that residents had been referred to these services, regularly reviewed and results of appointments were written up in the residents' notes however the advice provided by specialist services was not always transferred to the residents' care plan. For example inspectors reviewed the care plan of one resident who had been reviewed by the Speech and Language therapist. Although the advice was followed it was not always included in the residents care plan on nutrition.

There were systems in place to ensure residents' nutritional needs were met and that they did not experience poor hydration, but these required review. Residents were screened for nutritional risk on admission and their weight was checked on a monthly basis, or weekly when weight loss was observed. Some resident who had unintentional weight loss, had been assessed by a dietician and advice to increase calorific intake had been incorporated in the care plan. However; food and fluid monitoring charts were incomplete and did not contain sufficient information to be of therapeutic value. Residents whose skin integrity was at risk were prescribed nutritional supplements to assist wound healing. Nursing staff advised the inspector that there were no residents with wounds at the time of inspection. Staff had access to support from the tissue viability nurse if required.

Residents spoke favourably regarding the food provided. Mealtimes in the dining room/kitchen were unhurried social occasions in a domestic style setting. Staff were observed to engage positively with residents during meal times, offering choice and appropriate encouragement while other staff sat with residents who required assistance with their meal. Inspectors observed residents having their lunch. There was a choice of meals was offered. Special dietary requirements were communicated to the catering staff and inspectors found that residents' who required modified consistency diets and thickened fluids or diabetic or fortified diets, and also residents received the correct diet and modified meals were attractively served. Lunch was observed to be social occasions with appropriate table settings and sufficient staff to assist residents with the meal.

There were arrangements in place to review accidents and incidents within the centre, and residents were regularly assessed for risk of falls. Care plans were in place, however; in the sample reviewed they had not been updated following a fall. For example, one resident who had recently sustained a fall had their falls risk assessments updated but the care plan had not been revised post fall to include interventions to mitigate the risk of further falls. Furthermore, the residents care plan referred to assistive equipment no longer in use.

A cognitive impairment assessment was completed for all residents on admission however a dementia care plan was not developed to map where the resident was on their dementia journey, their level of independence, what they could do for themselves who they still recognised or the activities they could participate in.

The centre employed an activity co-ordinator who was observed during the inspection and spoken with by inspectors. A folder of photographs of events and activities attended was reviewed which showed pictures of residents engaged in gardening and on social outings. Residents were observed to be engaged in activities throughout the day including cards games, knitting, and passive exercises. Some residents said they liked

to watch TV or listened to music. In discussion with the activities co-ordinator she stated that she completed individual one to one sessions with residents with cognitive impairment who did not take part in group activities and these sessions were recorded in the activities folder reviewed by inspectors.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Inspectors reviewed practices in relation to prescribing and administration of medication. Medication was supplied in individual blister packs for residents by the pharmacy however staff then dispensed the medication into individual named containers prior to administering the medication. Although a risk assessment had been completed by the person in charge to support this practice, inspectors judged that it introduced additional risk to the administration of medication as the containers could be knocked over or a nurse could pick up the wrong pot from the tray and the "secondary" step of removing the medication from the original container created the potential for error.

Medication and prescription sheets included the appropriate information such as the resident's name and address, any allergies, and a photo of the resident and the General Practitioner's signature. There were no medication audits available other than those completed by the pharmacist. Controlled medication was kept in a secure locked cupboard and a register was maintained as per An Bord Altranais guidelines. Medications were securely stored in a locked cabinet in the treatment room.

A transfer letters was generated from the electronic care plan which summarised the residents' health, medications and their specific communication needs in the event of a hospital been admitted to hospital but a copy of this letter was not retained in the medical file. Inspectors were told that this information was stored electronically and could be retrieved if required.

The inspectors reviewed a number of 'End of life' care plans. Staff provided end of life care to residents with the support of their medical practitioner and palliative care services. Inspectors reviewed a sample of 'end of life' care plans that outlined the individual wishes of residents and their families including residents' preferences regarding their preferred setting for delivery of care. The assistant director of nursing said that all residents were offered the choice to move to a single bedroom. There were no residents under the care of the palliative care team at the time of inspection. Training records confirmed that staff had undertaken training in end of life care.

**Judgment:**

Non Compliant - Moderate

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

**Theme:**

Safe care and support

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

**Findings:**

The self assessment tool (SAT) completed by the provider for this outcome was rated compliant. Inspectors identified some areas for improvement.

Residents with whom the inspectors were able to communicate verbally said they felt safe and secure in the centre, and felt the staff were supportive. There were measures in place to ensure residents were safeguarded and protected from abuse. The safeguarding policy had been updated in November 2015 to reference the National Policy 'Safeguarding Vulnerable Persons at risk of Abuse' (2015). Staff training records indicated that all staff had completed annual training on the prevention, detection and response to abuse. Staff spoken with confirmed to inspectors that they had received this training and were aware of what to do if they suspected or were informed of an allegation of abuse.

There was a policy in place to inform practice for the management of behaviours and psychological symptoms of dementia (BPSD). Two residents were identified as having behaviours and psychological symptoms of dementia (BPSD). Prevention measures were identified in the care assistants' notes to prevent an escalation of the behaviours however there was no care plan in place to inform care practice. Residents were also appropriately referred to the mental health team of later life for specialist input which was evidenced in the files reviewed. Staff spoken to by the inspectors were knowledgeable regarding interventions that were effective in managing such behaviours including redirection and engaging with the residents.

Restraint management procedures were reviewed by inspectors. There were 9 residents who had bed rails in situ. Consent was obtained from the resident or their representative and the GP. A risk assessment was completed prior to the use of the restraint and this was regularly reviewed. The rationale for each type of physical restraint was outlined in the sample of files reviewed however the risk factors considered were not clear. For example, where a resident had other risk factors such as osteoporosis or fragile skin, the risks to the resident from using the restraint as opposed to other less restrictive options was not clearly outlined in the risk assessment documentation reviewed.

**Judgment:**

Non Compliant - Moderate

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

Person-centred care and support

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



The self assessment tool (SAT) completed by the provider for this outcome was rated compliant. Inspectors substantially concurred with this judgment but identified some areas for improvement.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with a dementia. 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). The observations took place in three 20 minutes periods in the main communal area and the dining room. Inspectors found evidence of good interactions with residents and positive connective care during each observation period. Inspectors found that residents with dementia were consulted with and supported to participate in the organisation of the centre and there were opportunities for residents to participate in activities that suited their interests and capabilities. A key worker system was in place and residents appeared comfortable with staff and looked for them when they needed support. Staff knew residents well and could describe for inspectors their backgrounds and specialist interests. Residents were also engaged in a variety of individual activities during the day from one to one conversation with care staff, to reading the newspaper and knitting or crocheting. Residents were asked if they would like to take part in the organised activities and staff interacted with them in a personable manner.

In the sample of care plans reviewed, the residents specific communication needs were assessed and recorded. A communication policy was available which included strategies to communicate with residents who have dementia. There was evidence that residents were consulted regarding the organisation of the centre. There were 4 meetings held during the previous year. Inspectors saw that a range of issues were discussed at the meetings however; the minutes did not record the actions to be taken in response to the issues raised and any actions taken to address the issues raised were not relayed to residents at subsequent meetings. Residents with dementia had access to advocacy services through an independent advocate who visited the centre regularly and attended resident meetings.

Those residents who shared a bedroom had privacy screens provided to ensure their privacy during personal care. Bedrooms and bathrooms had privacy locks in place. Inspectors observed that closed circuit television cameras (CCTV) were in use at the entrance to the centre, on corridors and in communal areas which did not afford the residents privacy and dignity . There was also poor signage provided to alert residents that they were being monitored. This was brought to the attention of the Assistant Director of nursing who stated that this would be reviewed.

There were no restrictions on visitors and residents could receive visitors in private. A room was available for residents to meet with visitors in private and there were no restrictions on visits.

Residents told inspectors that they were supported to make choices about their day to day lives. Residents with good cognitive ability choose what they liked to wear and inspectors saw residents looking well dressed. Residents spoken with said that they got up and retired according to their preference. Inspectors saw that newspapers,

televisions and radios were available. A phone was available for residents to make or receive phone calls in private. A polling booth was set up in the centre to facilitate residents to vote in the recent election.

**Judgment:**  
Substantially Compliant

#### ***Outcome 04: Complaints procedures***

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

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

**Findings:**  
The self assessment tool (SAT) completed by the provider for this outcome was rated compliant. Inspectors also identified compliance with this outcome.

A copy of the complaints policy was on display in the centre and residents spoken with said that they knew how to make a complaint and that they would complain to the person in charge or any of the staff if they had any concerns. The complaints policy was also available in the centres' residents' guide.

A complaints log was maintained by the PIC. A review of complaints recorded indicated that they were responded to within a suitable timeframe. The outcome of each complaint and if the matter was resolved to the satisfaction of the complainant was recorded. The inspectors found that complaints were appropriately responded to and records were kept as required. An independent appeals process was included in the centres policy. Details of an independent advocate available to residents were also included in the complaints policy.

**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 by the provider for this outcome was rated

compliant. Inspectors identified some areas for improvement.

The staff roster was reviewed by inspectors. An action from the previous inspection to review the rosters to include on-call arrangement was not addressed and has been restated in the action plan that accompanies this report. Inspectors observed that working times were not recorded on the roster using a 24 hour clock and codes were used to denote work shifts, for example N denoted the night shift with explanation or key to the explain the codes. The rosters indicated that in addition to the person in charge there was normally, two nurses (including the assistant director of nursing) and 6 health care assistants (HCAs) on duty in the morning. This reduced in the afternoon to 1 nurse, the person in charge and four HCAs. At night there was one nurse and two HCAs on duty. Inspectors observed that on the previous inspection there was four staff on duty at night. The rational for this reduction in staffing levels was not clear. The assistant person in charge stated that staffing levels and the skill mix were adjusted based on the assessed needs and dependency levels of residents and were regularly reviewed. An action has been included in the action plan that accompanies this report requiring a review of staffing level to ensure that there are appropriate staff numbers and an appropriate skill mix on duty at all times to meet the assessed needs of residents for the size and layout of the centre.

The recruitment procedures in place met the regulatory requirements. All staff including volunteer staff had An Garda Siochana vetting completed and recorded on their files. An induction programme was in place for new staff to support them in their roles. Staff were supervised appropriate to their role. Clinical competency assessment and regular performance management meetings were also conducted for staff. There was a clear management structure and staff were aware of the reporting mechanisms and the line management system.

A planned training schedule was available for the year and training records for the previous year were reviewed by inspectors. All staff had been provided with required mandatory training such as fire safety, moving and handling and adult protection. Training in nutritional assessment, dementia care, catheter care, wound care and end of life care had also been attended by staff. Staff were observed interacting with and supporting residents in a respectful and warm manner. From interactions observed during the inspection it was evident there were good relationships between residents and staff. One volunteer worked in the centre with roles and responsibilities clearly outlined in their written agreement.

**Judgment:**  
Substantially Compliant

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

**Theme:**  
Effective care and support

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

implemented.

**Findings:**

The layout of the centre provided a comfortable warm homely environment for residents . The building is designed around a circular corridor and allowed for movement of residents who wish to walk and there were grab rails on both sides of all corridors and to support residents with mobilising. Corridors had seating available in certain areas to allow residents to rest so as to avoid tiring and risking a fall. Corridors were dimly lit on the day of inspection but an electrician had been called and was carrying out repairs during the inspection.

The centre was found to be well maintained and visually clean. Floor coverings were clean and even. There were good levels of personalisation evident in residents' bedrooms. Residents spoken with confirmed that they felt comfortable in the centre. A key pad locking system was provided on the front door which was managed by staff to promote residents' safety. Relatives could access the building by using a code to open the door.

There was signage provided on some doors, however some had been removed and in general there was an absence of dementia friendly features to help orientate residents in the design and layout. For example, there was poor use of colour or visual cues or prompts to help aid recognition of different areas. Residents were observed to congregate in the main communal area and there was poor use of smaller communal spaces which would provide a quieter low arousal environment for residents with dementia. Communal spaces comprised a conservatory, a large day room, a smaller day room referred to as a 'quiet day room' and a large dining room. Residents generally met their relatives in their bedroom or in the smaller day room. A secure enclosed garden was available to residents which was well-kept and accessible off the main day room.

Inspectors observed that a bathroom had been adapted to provide a hairdressing facility for residents. Electrical sockets were installed and two hairdryers were observed to be plugged in. This risk was brought to the attention of the Assistant Director of nursing who gave assurances that that she would contact an electrician immediately to ensure the safety of this facility.

**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:***

Marie Matthews  
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>	Little Flower Nursing Home
<b>Centre ID:</b>	OSV-0000355
<b>Date of inspection:</b>	10/03/2016
<b>Date of response:</b>	16/06/2016

### 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:**

Care plans had not been updated following a fall to include interventions to mitigate the risk of further falls.

A dementia care plan was not developed to map where the resident was on their dementia journey, their level of independence, what they could do for themselves who they still recognised or the activities they could participate in.

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

**1. 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:**

The Care plan in question has been updated now to include interventions to prevent the risk of further falls.

Dementia care plans have been updated to include level of independence, what they can do for themselves, recognition of family members and activities they can participate in, a record of which had also been kept by the Activities Co-Ordinator.

**Proposed Timescale:** 13/05/2016**Theme:**

Safe care and support

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

food and fluid monitoring charts were incomplete and did not contain sufficient information to be of therapeutic value.

**2. Action Required:**

Under Regulation 18(1)(c)(iii) you are required to: Provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

Fluid Intake and Output charts are used as an additional measure to monitor against risk of dehydration. Nurses are directly informed by Health Care assistants if a resident is not taking sufficient fluids. All staff have been advised residents on fluid charts must have them properly completed prior to end of shift. Nurses are routinely checking the fluid charts prior to end of shifts to ensure this action is complied with.

**Proposed Timescale:** 30/06/2016**Theme:**

Safe care and support

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

Medication was supplied in individual blister packs for residents by the pharmacy however staff then dispensed the medication into individual named containers prior to administering the medication which introduced additional risk to the administration of medication as the containers could be knocked over or a nurse could pick up the wrong

pot from the tray and the "secondary" step

**3. 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:**

The Assistant Person in Charge has been in direct consultation with the pharmacist. A new system will be in place next month called Nu Life medication system, where medications for a particular time will be dispensed by the pharmacist in one sachet. In the meantime, medications are being dispensed from the medication trolley directly.

**Proposed Timescale:** 16/07/2016

**Outcome 02: Safeguarding and Safety**

**Theme:**

Safe care and support

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

Prevention measures were identified in the care assistants' notes to prevent an escalation of the behaviours but there was no care plan in place to inform care practice

**4. Action Required:**

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

Prevention measures have been added to the care plan to inform practice. This is an on- going process which changes as the residents journey progresses. A new care plan was in the process of being devised namely 'Dementia Journey', this has since been implemented.

**Proposed Timescale:** 13/05/2016

**Theme:**

Safe care and support

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

Risk factors considered before using a restraint were unclear. Where a resident had other risk factors such as osteoporosis or fragile skin, the risks to the resident from using a restraint as opposed to other other less restrictive options was not clearly outlined in the risk assessment documentation reviewed.



**5. 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:**

All risk factors are considered when assessing for the use of bedrails. There are 9 residents out of 43 with bedrails, bedrails are only used where deemed necessary for the protection of the resident. The risk of skin tears and osteoporosis are always considered as some residents have bed rail protectors in place to prevent such injuries. We are currently updating our risk assessments to state risk factors such as osteoporosis and fragile skin in relation to the use of bedrails.

**Proposed Timescale:** 22/05/2016

**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:**

Closed circuit television cameras (CCTV) were in use at the entrance to the centre, on corridors and in communal areas which was intrusive and did not afford the residents privacy and dignity was respect.

**6. Action Required:**

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

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

There is clear signage on entrance to the building that CCTV is in operation. CCTV is not used in bedrooms, bathrooms and areas where dignity could be compromised.

A risk assessment has been carried out and a privacy impact assessment is currently being devised. Residents have been consulted re: CCTV and they have stated they feel CCTV offers them more security and protection, knowing there is CCTV in operation where if an incident occurs footage can be accessed by the Person in Charge. Residents do not feel there is an invasion of their privacy, they see it as offering more protection warding off any incidents.

Residents have requested in the past, CCTV to be checked where they have misplaced belongings. This has proved to be integral in ensuring the residents comfort and safety With reference to the document by the Data Protection Commissioner- Ireland, Proportionality is of vital importance.

The CCTV policy is currently being updated to reflect the identity of the data controller, the purpose of the data, access requests and retention.

**Proposed Timescale:** 20/06/2016

### **Outcome 05: Suitable Staffing**

**Theme:**  
Workforce

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

The staff roster indicated that staffing at night time was reduced without clear rationale.

**7. 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:**

Staffing levels are monitored on a daily basis by the Person in Charge and weekly when organising the staff rota. Feedback is received from Nursing and Care staff on an ongoing basis. The number and skill mix of staff is determined by dependency levels and assessed needs of the residents.

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

**Theme:**  
Workforce

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

The staff roster was not written in a clear manner. Working times were not recorded using a 24 hour clock and codes were used to denote work shifts, for example N denoted the night shift with explanation or key to the explain the codes.

**8. 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:**

The staff rota is now done in the 24 hour clock. It is colour coded with an explanation on the same sheet to reflect emergency contact.

**Proposed Timescale:** 13/05/2016

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

**Theme:**

Effective care and support

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

There was poor use of smaller communal areas available which would provide a quieter low arousal environment for residents with dementia.

There was poor use of signage and visual cues to help orientate residents.

**9. Action Required:**

Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

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

Residents with Dementia are always given free choice of seating areas, on occasion they use the quieter rooms when they wish to do so. If and when a resident with Dementia becomes agitated, it is normal procedure for staff to take the resident in question to a quieter area.

More signage has been added to the existing signage. New signage was implemented in consultation with Dementia residents.

**Proposed Timescale:** 13/05/2016

**Theme:**

Effective care and support

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

Electrical sockets were installed in a bathroom adapted as a hairdressing facility which could pose a risk to residents.

**10. Action Required:**

Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

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

The electrician is currently addressing this.

**Proposed Timescale:** 22/05/2016