

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Dalkey Lodge Nursing Home
Centre ID:	OSV-0000771
Centre address:	Ardbrugh Road, Dalkey, Co. Dublin.
Telephone number:	01 285 1486
Email address:	dalkeylodge@ardmorecare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Dalkey Lodge Nursing Home Ltd
Provider Nominee:	John Martin
Lead inspector:	Nuala Rafferty
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	25
Number of vacancies on the date of inspection:	3

About monitoring of compliance

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

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

Regulation has two aspects:

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 26 July 2016 11:00 To: 26 July 2016 20:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Compliant
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 15: Food and Nutrition	Substantially Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Substantially Compliant
Outcome 18: Suitable Staffing	Substantially Compliant

Summary of findings from this inspection

This was an unannounced monitoring inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to follow up on matters arising from a registration inspection carried out on 13 November 2013 and to monitor progress on the actions required. This inspection also considered information received by HIQA in the form of notifications forwarded by the provider.

As part of the inspection, the inspector met with residents and staff members observed practices and reviewed documentation such as care plans, medical records and risk management processes.

Overall a good standard of nursing care was being delivered to residents in an atmosphere of respect and cordiality. Staff were knowledgeable of residents and their abilities and responsive to their needs. Safe and appropriate levels of supervision were in place to maintain residents' safety in a low key unobtrusive

manner. Residents' healthcare needs were met to a good standard with timely referral to medical and allied health professionals.

Recent changes to the clinical management team were found on this inspection with the person in charge and assistant director of care commencing in post in recent months. Through an assessment of fitness process, both demonstrated good knowledge of their role and responsibilities and had sufficient experience and qualifications as required by the legislation.

The inspector found there was a good level of compliance with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Quality Standards for Residential Care Settings for Older People in Ireland. In particular there was a good system of governance and an emphasis on continual improvement. Some areas of ongoing improvement were identified with regard to records, person centred care and staffing.

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 02: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A clearly defined management structure which identified the lines of authority and accountability was in place. The centre is part of a group that includes two centres and has an overarching governance structure in place to support the person in charge and assistant director of care. This included;

- a managing director who was also the provider representative
- group director of care
- human resources manager
- head chef and maintenance manager.

Systems were in place to monitor quality and safety of care in place while data was being collated on a monthly basis on key performance indicators (KPI's) of clinical care such as; falls: pressure injuries: medication errors and nutrition management. These KPI's are used as a way to assess the standard of care being delivered in the centre.

A separate multidisciplinary team meeting was held on a weekly basis which was attended by the person in charge (PIC) assistant director of care, nurses, healthcare assistant and activities co-ordinator. The inspector looked at a sample of the minutes of these meetings. This team reviewed the data collated on the KPI's and also discussed issues such as: incident management: infection control: mandatory training and individual resident's issues.

Weekly meetings of the senior management team took place and a sample number of minutes of these meetings held were also viewed. The senior management team considered clinical and non clinical risk indicators, progress on quality improvement projects, staff training, recruitment, equipment, finance and future service developments. An external consultancy group was engaged by the provider to audit systems and performance in a number of areas that the management team had identified at the beginning of the year. These included audits on records management; residents' activities programme and complaints procedure. Reports from the consultancy group

were reviewed which identified a number of improvements required in areas such as complaints management and greater variety in activities programme.

An annual review of safety and quality of care was in progress. A draft report was prepared by the provider and inspectors looked at this draft report. The report identified key performance indicators such as; staff recruitment, retention and training; complaints analysis and service developments. Other quality care indicators were referenced to indicate the standard of and safety and quality of service being delivered.

Judgment:

Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The centre was managed by a suitably qualified and experienced nurse. The person in charge took up the position since the last registration inspection in the centre. He held authority, accountability and responsibility for the provision of the service and also had the qualifications and experience required by the legislation.

Through an assessment process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions and was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents.

Judgment:

Compliant

Outcome 05: Documentation to be kept at a designated centre

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

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Overall, general records as required under Schedule 4 of the Regulations were maintained including key records such as appropriate staff rosters, accident and incidents, nursing and medical records. Planned rosters were in place in all units and an actual working rota was maintained. All of the operational policies and procedures as required by Schedule 5 of the Regulations were available and were reviewed on a regular basis and within the three timeframe as required by the regulations.

Residents' privacy was not fully respected by the storage of confidential information about their care. Archived files were found stored in an unlocked and open area of a communal room. The files were stored on top of locked cupboards behind open sliding doors that did not have a lock. This was brought to the attention of the person in charge who addressed the problem by storing them in an appropriately locked press before the end of the inspection.

Judgment:

Substantially Compliant

Outcome 06: Absence of the Person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Suitable arrangements were in place for periods of absence of the person in charge and the provider complied with his responsibilities to notify the Authority when a change occurred to both the person in charge and the nominated person to replace them. The fitness of the assistant director of care to replace the person in charge in the event of an absence was determined through an assessment process during the inspection. He was found to be resident focused, aware of the roles and responsibilities of the position and had the qualifications and experience required by the legislation.

Judgment:

Compliant

Outcome 07: Safeguarding and Safety

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

Theme:

Safe care and support

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

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

Findings:

Promotion of a restraint free environment was found to be maintained with reductions in the use of bed rails and lap belts noted. Revised assessments were fully completed.

Evidence of alternatives considered or trialled was available and included or referenced in the assessments or in associated care plans.

The management of risks associated with negative peer interactions, absconsion and concerns in relation to unmet needs raised by relatives were also being appropriately managed and responded to. Historical investigations and concerns raised by families were being fully reviewed by the senior management team and measures were being implemented to reduce and prevent recurrence.

Improvements to care planning and staff knowledge of good practice in providing positive behaviour supports to persons with responsive behaviours were found.

Staff had been provided with training on the prevention of elder abuse, although it was noted that all staff had not attended training provided. All staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse.

Procedures to protect residents, such as a robust recruitment system, staff induction and training were also in place and implemented.

In conversations with them, residents who chatted to the inspector said that they felt safe and secure in the centre. It was noted that the centre policy on prevention of elder abuse was updated to reflect the most recent HSE guidance on safeguarding vulnerable adults.

Judgment:

Compliant

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building.

The internal and external premises and grounds of the centre appeared safe and secure, with appropriate locks installed on all exterior doors and a register of visitors was available. A CCTV system was in place externally. The centre was found to be visibly clean and clutter free.

Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. Certification of testing and servicing of extinguishers, fire retardant materials and the alarm system were documented. The building's fire and smoke containment and detection measures were appropriate to the layout of the building and exits were free of obstruction. A personal evacuation plan for each resident that identified their level of mobility and assistance required to evacuate, possible compliance with an evacuation process or whether close supervision was needed following evacuation was available in each bedroom.

All staff had received training in fire safety within the past 12 months and were familiar with what actions to take in the event of a fire alarm activation. The Inspector was told regular fire drills were held which included activation of the fire alarm, staff responded by checking the fire panels on each floor which were located at the nurses' station. All staff were familiar with the principles of horizontal evacuation. Regular simulated evacuation drills were held. These drills also included simulation of an actual evacuation using night staffing levels to determine the competency of staff to use evacuation equipment such as evacuation sheets and practicing the principles of all forms of evacuation.

A comprehensive emergency management plan was in place to guide staff in responding to a range of incidents such as emergency evacuation and resident's who leave the centre without staff knowledge. Staff spoken to were familiar with the principles of the plan and aware of the parameters to which a search would extend. An emergency pack was in place to support the implementation of a search. A risk register was established which was regularly reviewed and updated. Governance and supervision systems were in place to monitor residents at risk of falls, wandering or negative interactions.

Judgment:

Compliant

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

The inspector found there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of blister packed medication. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Medication administration practices were found to adhere to current professional guidelines.

Medication audits were conducted in the centre and inspectors they were conducted by the external pharmacist with nursing and medical inputs. These audits covered most aspects of good medication management practices and were conducted on a regular basis. The audits looked at aspects such as; storage, labelling, administration records controlled medicines and temperature controls on medicine refrigeration.

Although both prescribing and administration practices were found to be appropriate on this inspection, a pre printed medication administration sheet was in place. This sheet had times printed across the top to indicate the time at which the medicine was given to the resident. The nurse entered the name or corresponding code under the assigned time and signed it. But it was noted that the times of administration on this sheet did not correspond to the times on the prescription sheet for some of the medicines. It was also noted that the actual times medicines were administered by the nursing staff were not accurately recorded where this differed from the time the medicine was prescribed for administration

This was brought to the attention of the PIC and was addressed prior to the end of the inspection.

Judgment:

Substantially Compliant

Outcome 11: Health and Social Care Needs

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

needs and circumstances.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

There was evidence that the well being and welfare of residents were being maintained through the provision of a good standard of nursing medical and social care.

Residents had access to GP services. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services.

Evidence of access to medical and allied health professionals was found with documented visits, assessments and recommendations by dietician speech and language therapists, physiotherapy and occupational therapist reviews. Transfer of information within and between the centre and other healthcare providers was found to be good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were seen.

Samples of clinical documentation including nursing and medical records were reviewed these showed that all recent admissions to the centre were assessed prior to admission. The pre admission assessment was generally conducted by the person in charge or assistant director of care who looked at both the health and social needs of the potential resident. However, although the assessment tool was comprehensive it was not always fully completed. It was found that a formal diagnosis of dementia or cognitive impairment from a consultant specialist or general practitioner was not always available. It was also noted that an assessment of capacity for those residents with a formal or suspected diagnosis of dementia or other cognitive impairment had not been conducted. This was an issue where residents were asked to give consent for procedures or photography. It was found that some residents or their relatives were asked to sign consent forms that did not specify the reason for their consent. This meant that the reason had not been fully explained and where a resident did have capacity they could not make an informed decision.

A system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health was in place. Care plans were found to be detailed enough to guide staff on the appropriate use of interventions to manage the identified need. Although in general care plans reflected the care delivered, further improvements were found to be required. The checks in place, although regular, did not consider the effectiveness of the plans to make sure they were detailed enough to maintain or improve a resident's health. Examples included; Palliative or end of life care plans did not reference residents wishes or preferences for religious or spiritual preference or to facilitate supports for place of death or funeral arrangements. Skin Integrity care plans did not reference frequency of re positioning to maintain blood flow and reduce pressure. Wound care charts were not in place to guide staff on the

management of some pressure related injuries.

It was also noted that the recording of care interventions was not always timely. On a sample of records reviewed, it was found that some of the care delivered was not recorded until late in the afternoon when all of the care delivered was inputted into the record at the same time. For example, where residents require food or fluid intake and output monitoring.

Judgment:

Non Compliant - Moderate

Outcome 15: Food and Nutrition

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents' weights were checked on a monthly basis, and where required, daily intake charts were in place to monitor food or fluid intake.

Menus were available and all residents were offered choice at each meal. The inspector observed residents having their lunch in the dining room, where a choice of meals was offered. All staff sat beside the resident to whom they were giving assistance and were noted to patiently and gently encourage the resident throughout their meal. However, it was noted that some staff were assisting two residents with their meals at the same time. The staff person sat in between two residents and gave each one assistance on an alternate basis. At one point, a staff person, who was assisting one resident, left the resident to collect the nutritional supplements in preparation for later and a second staff person, who was already assisting two people, then tried to assist this resident. This involved the staff moving over and back between two tables for a short period.

In another instance a staff member who began to give assistance to a lady known to require lots of encouragement. The resident had only had two to three mouthfuls of her meal and seemed to be enjoying it when the staff person had to leave and bring another resident to the bathroom. When she returned about 10 minutes later, the resident refused to eat anymore. The staff person made lots of efforts to encourage further intake, including having an alternative hot meal brought from the kitchen, but the resident could not be persuaded to eat anymore.

Judgment:

Substantially Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Residents' rights, privacy and dignity was respected with personal care delivered in their own bedroom or in bathrooms with privacy locks and the right to receive visitor's in private.

There were no restrictions to visiting in the centre and some residents were observed spending time with family or friends reading newspapers or chatting in their bedrooms.

Choice was respected and residents were asked if they wished to attend Mass or exercise programmes, control over their daily life was also facilitated in terms of times of rising /returning to bed and whether they wished to stay in their room or spend time with others in the communal rooms. The right to vote in national referenda and elections was facilitated with the centre registered to enable polling.

Staff were observed to interact with residents in a warm and personal manner, using touch eye contact and calm reassuring tones of voice to engage with those who became anxious restless or agitated.

Information on the day's events and activities was prominently displayed in the centre. Two activities coordinators delivered the programme which included both group and one to one activities. Inspectors were told that one to one time was scheduled for residents with more severe dementia or cognitive impairment or who would not participate in the group activities, and that this time was used for sensory stimulation such as providing hand massages. Other dementia relevant activities were included in the programme such as reminiscence and sonas. Residents life stories were collated by staff who were aware of them and inspectors were told they would be used to inform reviews of the programme going forward.

Access to the community was facilitated through occasional trips to places such as the maritime Institute and Library. An outing was arranged for the bank holiday weekend for some residents to attend the Dalkey Vintage Festival.

Residents and Relatives who spoke to the inspector were generally very satisfied with the care provided. All said that staff were respectful and kind. All said they felt safe and trusted staff to look after them well. Some did say that there were times when staff were under pressure and did not always have time to respond promptly to requests or were rushed particularly at night.

Judgment:
Substantially Compliant

Outcome 18: Suitable Staffing

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

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

Suitable and sufficient direct care staffing and skill mix were found to be in place to meet the needs of the current resident profile.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified.

Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place. Cover for planned and unplanned leave was provided within the current staff complement. This also included availability of staff to cover unplanned absences on night shifts.

Records reviewed showed that staff had been provided with opportunities to receive updated training in areas such as: safeguarding; moving and handling; fire safety; cardiopulmonary resuscitation; first aid; dementia care and food hygiene.

Appropriate and respectful interactions were observed throughout the day between residents and staff. Overall it was noted that resident's dignity and choice was respected during care interventions and in their daily lives.

A formal staff appraisal system was established that discussed the continuous performance and training of staff with each staff member.

The number and skill mix of ancillary staff were not sufficient on the day of inspection to ensure person centred care was delivered to all residents at all times.

Only one housekeeper was on duty when 1.5 were scheduled on the roster. This meant that direct care staff were involved in housekeeping related tasks and were unable to provide person centred care at all times. It was found that clarity on the roles and responsibilities of each grade of staff was required and priority needed to be given to more person centred practices rather than task allocation. Findings referenced under outcomes 16 and 11 regarding dignified assistance at mealtimes and timely recording of care interventions were linked to the roles of staff. The inspector observed that healthcare assistants were involved in tasks more appropriate to a housekeeping role.

The care staff were required to tidy and clean the dining area during and after meals. This was listed on a staff allocation sheet as being of a higher priority than documenting resident's intake.

The inspector was told that the care staff were involved in these tasks further to a review of staffing which had reduced the number of housekeeping staff in the centre from two whole-time equivalents to 1.5 per day. However, on the day of inspection only 1 whole-time equivalent housekeeping person was rostered.

Judgment:

Substantially 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:

Nuala Rafferty
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:	Dalkey Lodge Nursing Home
Centre ID:	OSV-0000771
Date of inspection:	26/07/2016
Date of response:	01/09/2016

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 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Resident's privacy was not fully maintained through inappropriate storage of confidential information. Some records were stored on an open shelf in a communal area.

1. Action Required:

Under Regulation 21(6) you are required to: Maintain the records specified in paragraph

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

(1) in such manner as to be safe and accessible.

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

- We acknowledge that there was a variance from our accepted and normal practice in the storage of records as highlighted by the inspector. We take our responsibilities to maintain the privacy of records very seriously and our Senior Management Team have conducted a comprehensive review of our adherence to our policy for the Creation, Storage, Access to and Destruction of Records - Complete
- All records are now stored securely in a locked press, the access to which is controlled, at all times – Complete
- A unified healthcare record which encapsulates all paper based records is currently in development to replace our existing individual resident record – For completion by 31/10/16
- All staff nurses will undertake Records Management self-directed learning on or before 30/09/16 to update their knowledge in the safe and compliance storage of records – For completion by 30/09/16
- The person in charge has made provision for appropriate space and systems for the storage of records – Complete
- Our policy DL-VC-005 Storage Security and Destruction will be updated to give specific practical guidance to staff and distributed to all relevant staff members based on the above revisions to our practice – For completion by 31/08/16
- An audit of Records Management will be carried out as the final close out step of this action plan by the Director of Care (Person in Charge) and Assistant Director of Care – For completion by 07/10/16
- The required actions outlined above will be monitored, recorded and evidenced in our Quality Management System Audit module with Root Cause, Corrective Action and Preventative Action to enable continuous quality improvement and oversight by the Registered Provider and Senior Management Team – For completion in stages upon completion of each of the above actions but no later than 31/10/16

Proposed Timescale: For completion by 31/10/16 in stages as outlined above

Proposed Timescale: 31/10/2016

Theme:

Governance, Leadership and Management

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

The delivery of care was not always recorded in a timely manner to determine that the care plans in place were appropriately and fully implemented.

2. 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 conducted a review of the recording of care delivery in the context of Records Management and Health and Social Care to identify issues with the timeliness of recording – Complete
- Policy and procedure training has been completed with staff to ensure all staff are knowledgeable about timelines for recording of care interventions – Complete
- The Assistant Director of Care is reviewing each residents daily care interventions record 3 times per day to ensure care interventions are recorded in a timely manner and addressing any delays by means of 1 to 1 staff support and supervision – Complete and continuing on an ongoing basis
- We have conducted a system wide review of our electronic care record and made changes to simplify and streamline the process of care recording to facilitate improvements in the timeliness of recording – Complete
- The required actions outlined above will be monitored, recorded and evidenced in our Quality Management System Audit module with Root Cause, Corrective Action and Preventative Action to enable continuous quality improvement and oversight by the Registered Provider and Senior Management Team – Complete

Proposed Timescale: Complete

Proposed Timescale: 01/09/2016

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Residents capacity was not determined assessed or reviewed prior to their involvement in decisions regarding consent to unspecified procedures or photography

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:

- We have reviewed our practices with regard to consent taking into account the recent changes in legislation and the enactment of the Assisted Decision Making (Capacity) Act 2015 along with our internal policies and procedures relevant to the Theme of Residents Rights – Complete
- The Person in Charge and Group Director of Care have attended familiarisation training with regard to the assessment of capacity in line with the legislation now enacted and will update key staff as appropriate – Complete
- Training sessions will be held with nursing staff to cascade knowledge and skills with regard to assessing capacity in line with the legislation now enacted – For completion

by 30/09/16

- Our pre-admission assessment process will include evidence of whether a formal assessment of capacity has previously been undertaken and the results of that assessment. Where no formal assessment has been previously undertaken, the pre-admission process will identify residents who require a formal assessment of capacity and guide staff to a framework to access such a formal assessment – For completion by 30/08/16
- The completion of a general consent form for care and treatment will be discontinued with immediate effect – Complete
- Specific guidance will be issued to staff to clarify which procedures and interventions required specific written informed consent and which require verbal consent – Complete
- The consent form for procedures or interventions requiring written informed consent will be revised to record the specific nature and purpose of the procedure/intervention; the benefits; the risks (if any); and the right to withdraw consent at any time – For completion by 30/08/16
- The required actions outlined above will be monitored, recorded and evidenced in our Quality Management System Audit module with Root Cause, Corrective Action and Preventative Action to enable continuous quality improvement and oversight by the Registered Provider and Senior Management Team – For completion in stages upon completion of each of the above actions but no later than 30/09/16

Proposed Timescale: For completion by 30/09/16 in stages as outlined above

Proposed Timescale: 30/09/2016

Theme:

Effective care and support

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

Some care plans were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.

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:

- An internal audit has been completed on our Care Planning processes and training needs identified regarding the measurement and recording of the effectiveness of interventions and evaluation of plans of care – Complete
- An internal care planning champion has been identified who will work with clinical staff over the following 6 weeks to improve and develop skills in evaluation of care plan interventions – For completion by 30/09/16
- A revised End of Life Care suite of tools is in development to improve the assessment and care planning of residents needs with regard to End of Life care which will ensure

comprehensive capture of residents needs/wishes – For completion by 31/10/16

- Care Plans for Skin Integrity will reflect the specific frequency of repositioning where a resident requires such supports – For completion by 30/08/16
- Actions as outlined in Action Plans 2 & 3 are complimentary to this action plan and will be completed as outlined above
- The required actions outlined above will be monitored, recorded and evidenced in our Quality Management System Audit module with Root Cause, Corrective Action and Preventative Action to enable continuous quality improvement and oversight by the Registered Provider and Senior Management Team – For completion in stages upon completion of each of the above actions but no later than 31/10/16

Proposed Timescale: For completion by 31/10/16 in stages as outlined above

Proposed Timescale: 31/10/2016

Theme:

Effective care and support

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

Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

5. Action Required:

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

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

- A review of all existing care plans is in progress to identify the effectiveness of care interventions for each resident on an individual basis– For completion by 30/09/16
- Training for staff as outlined in Action 4 is ongoing – For completion by 30/09/16
- All care plans are reviewed at a minimum of every 3 months and these reviews are managed and monitored by our electronic care planning system - Complete

Proposed Timescale: 30/09/2016

Outcome 15: Food and Nutrition

Theme:

Person-centred care and support

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

Resident's privacy and dignity was not fully maintained through inadequate person centred attention at meal times.

6. Action Required:

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

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

- We have conducted a review of resident individual needs for assistance at meal times
 - Complete
- Training has been provided to staff on appropriate means of providing individualised support with regard to residents rights, dignity and respect – Complete
- The person in charge will, in conjunction with the catering team, make suitable arrangements for those residents requiring support to receive uninterrupted assistance at meal times in a person-centred manner by revising staff allocation of duties and the extension of lunch time service provision and introducing the capability to hold a second sitting if residents so choose – For completion by 30/09/16

Proposed Timescale: 30/09/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The number and skill mix of ancillary staff were not sufficient on the day of inspection to ensure person centred care was delivered to all residents at all times.

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:

- We have conducted a review of ancillary staffing with the service according to the needs of residents and identified that the existing number of staff is appropriate to meet residents needs (1.5 ancillary staff per day) – Complete
- The registered provider has arranged for the recruitment of additional ancillary staff to improve our capability to respond to unplanned absence as occurred on the day of the inspection – Complete
- The roles and responsibilities of ancillary staff has been reviewed and revised based on the outcome of this inspection report to better align with the needs of residents and the service – Complete
- A number of responsibilities previously assigned to the healthcare assistant role have been transferred to ancillary staff responsibilities - Complete

Proposed Timescale: 01/09/2016

