

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Waterford Nursing Home
Centre ID:	OSV-0000255
Centre address:	Ballinakill Downs, Dunmore Road, Waterford.
Telephone number:	051 820 233
Email address:	waterfordnursinghome@mowlamhealthcare.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Mowlam Healthcare Services Unlimited Company
Provider Nominee:	Pat Shanahan
Lead inspector:	Gemma O'Flynn
Support inspector(s):	Sheila Doyle
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	54
Number of vacancies on the date of inspection:	6

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.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

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: 17 October 2016 09:45 To: 17 October 2016 17:35

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 - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Substantially Compliant

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also followed up on the progress of completion of actions required to address non-compliances with the regulations from the two previous inspections in the centre in February 2016. There were 14 actions identified from the last inspections. The findings from this inspection confirmed that 11 actions were satisfactorily completed and three actions had not been satisfactorily progressed.

As part of the thematic inspection process, providers were invited to attend seminars which explained the inspection process. In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care. Prior to the

inspection, the provider completed the 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) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

The judgements of the self-assessment and the inspection findings are set out in the table above. There was a total of 54 residents in the centre on the day of this inspection, 25 residents had a formal diagnosis of dementia and three other residents had symptoms of dementia. The centre did not have a separate dementia specific unit. Residents' accommodation was arranged over two floors.

Inspectors met with residents, relatives and staff members during the inspection. They tracked the journey of residents with a diagnosis of dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records and staff files. Inspectors examined the relevant policies including those submitted prior to this inspection. There were policies and procedures in place for safeguarding residents from abuse. Overall, staff were observed to be respectful, supportive and caring towards residents and demonstrated a good awareness of residents' needs. However, on occasions the care provided was neutral or task orientated in its delivery as opposed to positive connective care. Residents and relatives who spoke with inspectors indicated that they were happy with the staff who worked in the centre and reported that they did their best. However, residents, relatives and the majority of staff members who spoke with inspectors conveyed that they found that the centre was short staffed. This outcome merited a judgment of major non compliance and the provider was required to undertake a review of staffing levels. These findings are discussed throughout the report and in the associated action plan at the end of the report.

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:

Residents' healthcare needs were met through timely access to medical treatment. Ten local general practitioners (GPs) visited the centre and an out-of-hours service was also available.

Prior to admission, pre-assessment of residents were conducted to ensure that the residents' needs could be fully met in the designated centre. Inspectors formed the judgment that the pre-assessment process was not sufficiently robust to adequately identify the resources required for prospective residents. For example, a resident was assessed by specialist services two months following admission. The specialist found the resident was unsuitably placed in the centre as they required more specialised care. Staff who spoke with inspectors indicated that this resident required significant individualised support.

Records demonstrated that residents had access to the services of allied health professionals such as dietitians, speech and language therapists, chiropody and optical services. However, in a file reviewed, whereby a medical professional had advised that a speech and language referral was required in response to staff concerns that the resident's swallow had disimproved, it was evident that the referral had not been instigated. There was no documented rationale for this omission.

There were systems in place to encourage the prevention and early detection of ill health. For example, monthly weight and blood pressure checks were carried out for all residents. Residents who had been identified as being a risk from a nutritional perspective were weighed weekly. Records of urinalysis and blood profiling were retained in residents' medical files.

Assessments and care plans were reviewed on at least a four monthly basis. Assessments included review of matters such as dependency levels, nutrition status, skin integrity and falls risk. Overall, inspectors found care plans gave good guidance of the person's needs and directed consistent care. Staff who spoke with inspectors relayed

information that was recorded in care plans. However, there were some gaps in documentation. For example, a resident with diabetes did not have a specific care plan in place, however, records demonstrated that blood sugar checks were carried out on a weekly basis as per the person in charge's statement to inspectors. A discharge care plan had not been created for a resident, despite there being a plan in place for a resident to be transferred. The person in charge was able to discuss the plans in place, however, as stated, a care plan for same was not available. Systems were in place to ensure that relevant information about residents with dementia was provided to another care setting, home or hospital setting. The person in charge stated that residents were generally accompanied to the hospital by a care staff member.

The person in charge showed documentary evidence to inspectors confirming that care plans had been discussed with next of kin. This was an action following the previous inspection.

There were written policies and protocols in place of end-of-life care. However, in the sample of files reviewed, end-of-life care plans were not in place for all. Inspectors reviewed the file of resident who was recently deceased. An end-of-life care plan had been in place and evidenced that family had been involved, kept informed of the resident's changing condition and facilitated to be with their loved one twenty four hours a day. Records demonstrated that a palliative care assessment had been completed and the resident had been seen by their GP for pain management. Senior nursing staff said that referrals to palliative care would occur via GP referral where necessary and pain management tools were accessed as and when required. The residents care plan confirmed the residents choice for their place of death and highlighted their religious preferences. A record indicating that the resident had been anointed was available.

There was a policy in place for monitoring and recording nutritional intake. A validated nutritional screening tool was utilised to determine nutritional status and monthly weights were recorded. There was access to fresh drinking water and other drink choices at all times. There was evidence of review by appropriate allied health professionals upon review of resident files and this information was relayed to the catering staff. Food was prepared in sufficient quantities and residents expressed satisfaction with the quality of their meals. Evening meals were served at approximately 16:45hrs which had changed from 16:00hrs since the previous inspections.

Medication management practice and procedures were in line with professional guidelines. Inspectors observed that medications were stored and administered safely to residents by a registered nurse. Issues identified on the previous inspections pertaining to the administration of crushed medication, the use of insulin pens, maximum dose of as required medication, allergy information and guidance for use of psychotropic drugs had been satisfactorily addressed and the management of same was found to be in line with current guidance for nurses.

Falls care plans were reviewed and reflected the associate assessment. Nursing notes demonstrated that residents were referred to physiotherapy following a fall and recommendations were seen to be included in the relevant care plan.

Wound care management was reviewed and it was evident that staff had access to

external expertise where required. Wound care plans were in place but required further development to guide practices such as the frequency of photographing the wound and frequency of recording the measurements of the wound to monitor its progress to ensure consistent delivery of care in this regard as the person in charge said these interventions should be completed weekly, however, records indicated monthly recordings of same.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

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

Findings:

There was a policy on, and procedures for, the prevention, detection and response to abuse. Staff had received training and this was confirmed by staff who spoke with inspectors and via the centre's training matrix record. Staff recruitment procedures were in place to ensure residents were safeguarded. However, not all files reviewed held a vetting disclosure as required by the Regulations. It was confirmed that there was two members of staff working with residents who did not hold the required vetting disclosure. Upon review of volunteer files, it was evident that not all volunteers had a vetting disclosure in place. One staff member received their vetting disclosure prior to the close of inspection. The Director of Care Services, who was representing the provider at the feedback meeting, was reminded that all staff require a vetting disclosure under the 2013 Regulations and the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016, and undertook to ensure that the centre was in full compliance with this Regulation by stating that only staff/volunteers with the required vetting disclosure would be rostered on duty. This assurance was provided verbally with a commitment to provide the assurance in writing. The written assurance had not been submitted prior to the preparation of this report and the inspector had to contact the relevant person to request same.

There was a policy on the management of behaviour that is challenging. There were a number of residents in the centre who had behaviours and psychological symptoms of dementia. Standardised assessment tools were in use to record antecedents, behaviours and consequences in an effort to determine any triggers and inform the development of care plans. Staff spoken with, including household staff, were familiar with resident's behaviours and could describe particular interventions well. During the inspection the inspectors observed that staff approached residents in a sensitive and appropriate manner. There was evidence staff had completed training in behaviours that challenge. Where required, residents had access to mental health services.

Overall, a restraint free environment was promoted. There was a policy on the management of restraint. 17 out of 54 residents were using bed rails. Consent for their use had been signed, the general practitioner (GP) had been involved in the decision making process and the inspector viewed the risk assessments which had been undertaken prior to their use. Inspectors observed that alternative measures such as low low beds, crash mats and bed alarms were in use.

The centre managed some residents' finances. Records were reviewed and found to be transparent. The Services Manager confirmed that the centre's management of finances was subject to two internal audits per year and one external audit. All incoming and outgoing monies received by the services manager had two staff signatures on the receipt document. The services manager stated she was the only person with access to residents' petty cash and arrangements were in place at times she was absent should a resident wish to access their funds. A random check of resident finances tallied with records.

Judgment:

Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that residents including residents with a dementia related condition had limited opportunities to participate in activities in accordance with their interests and capacities.

As part of the inspection, inspectors spent a period of time observing staff interactions with residents with a dementia. The observations took place in the activity room, the day rooms upstairs and downstairs and the upstairs dining room at lunch time. Observations of the quality of interactions between residents and staff for selected periods of time indicated that only 25% of interactions demonstrated positive connective care, 25% reflected task orientated care while 50% indicated neutral care. These results were discussed with the staff who attended the feedback meeting.

Inspectors noted that for long periods of time during the inspection, although a staff member was providing supervision in the day rooms, this did not include the provision of any activities. Staff, residents and relatives confirmed this to be the case. While an activity coordinator was employed her duties included supervision of the day room and assisting at meal times which limited the amount of time available to engage in meaningful activities. Individual sessions were also very limited for residents who did not

wish to engage in group activities. For example, a number of residents remained in their bedrooms throughout the day of the inspection. Inspectors observed very limited staff interaction with these residents and residents told inspectors that the centre was short staffed and they didn't have the time to sit and chat with residents.

Inspectors saw that although staff had received training in a therapy with a focus on promoting communication, especially for people with dementia) sessions were no longer held on a regular basis. Similar issues were noted with a therapy used to improve and maintain memory function. Staff spoken with said that they did not have sufficient uninterrupted time to run these sessions.

Inspectors found that were satisfied residents' privacy and dignity was respected although some improvement was required to ensure that all residents were consulted on a regular basis.

There was a residents' committee but it was noted that meetings had lapsed with the previous meeting taking place six months earlier. Inspectors did note that this was now scheduled for later this month and notices were on display around the centre. However there was limited evidence that residents with dementia were included at this committee or if alternative arrangements were in place to ensure that they were consulted as regards the organisation of the centre.

Inspectors were satisfied that residents' religious and civil rights were supported. Each resident had a section in their care plan that set out their religious or spiritual preferences. Maas was celebrated on a regular basis within the centre and some residents returned home with family members. Advocacy services were available.

Judgment:

Non Compliant - Moderate

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:

A complaints process was in place to ensure the complaints of residents including those with dementia, their families or next of kin were listened to and acted upon. The process included an appeals procedure. The complaints procedure which was displayed in the front hall met the regulatory requirements.

A complaints' log was maintained on a computerised system and inspectors saw that it contained details of the complaints, the outcome of the complaint and the complainants' level of satisfaction with the outcome. Records reviewed showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant

was recorded.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

No actions were required from the previous inspection.

Findings:

Inspectors found that a review of staffing levels was required to ensure that there was sufficient staff on duty at all times.

There were 54 residents in the centre on the day of inspection. Of those, 32 were assessed as being maximum dependency, 15 were assessed as being high dependency, four were assessed as being medium dependency and 3 were assessed as being low dependency. Staff, residents and relatives told inspectors that there was insufficient staff on duty particularly at weekends. Inspectors saw that the activity coordinator, who was scheduled from 10am to 4pm, Monday to Friday, was involved in both the supervision of residents and the provision of care to residents. This limited her time available to engage residents in meaningful activities and this is discussed under outcome 3. However as she worked Monday to Friday this meant that one less staff member was available at weekends.

Inspectors viewed the rosters and noted that the day before inspection two staff members had not turned in for work but no replacements had been provided. The person in charge confirmed this to be so.

Inspectors saw that residents very often required one to one supervision during episodes of behavioural and psychological signs of dementia. This also reduced the staff available for other residents.

Relatives told inspectors that they visited at lunch time as one relative explained their relative (resident) required additional time to have lunch and he needed to make sure this was available. Another relative spoke with inspectors and showed them a letter they were going to submit for review at the residents' upcoming meeting. The letter set out concerns relating to the staffing levels in the centre. Another relative said that at times they could be waiting 15 minutes to gain entry to the centre.

Inspectors saw that pre-admission assessments had been undertaken but it was unclear if this took into account the additional needs of some of the residents. Residents and relatives reported delays in answering call bells. Inspectors were unable to verify this as it was not possible to monitor response times from the system in place. Inspectors did one spot check and noted that it took four minutes for the bell to be answered, the

director of care services said that a timeframe of one minute is what she would deem acceptable. This was also discussed in detail at the end of inspection.

Inspectors requested that the provider undertake an immediate review of staff levels and submit a report to HIQA demonstrating that staffing levels had been reviewed and how they met the current needs of residents in the centre. The report was received within the timeframe agreed and it determined that some changes to staffing was required. For example, as per the report, an extra carer has been rostered on duty from 8am to 6pm and the 'twilight' care assistant shift from 4pm to 10pm will be solely allocated to the first floor instead of being assigned to work on both the ground and first floor. The provider has undertaken that staffing levels will be closely monitored by the person in charge on an ongoing basis and changes will be made as required in response to residents' changing needs.

Inspectors reviewed a sample of staff files and noted that some did not meet the requirements of the Regulations. In two of four staff files reviewed, there was not a satisfactory history of gaps in employment.

Up to date registration numbers were in place for nursing staff. Inspectors reviewed the roster which reflected the staff on duty.

Inspectors saw that an extensive training plan was in place. Training undertaken included mandatory training in fire safety, safeguarding vulnerable adults and manual handling. Additional training courses included medication management, infection control and food safety. Staff had received training in dementia care and behaviours that challenge as evidenced in the training matrix and confirmed by staff who spoke with inspectors.

Inspectors saw that saw that a robust induction programme was in place for new staff which included the provision of information to the staff member on issues such as confidentiality, health and safety issues, maintenance and policies. A clinical skills handbook was also in use which included competency assessments in skills such as oral care and blood sampling and this was signed off once completed.

Appraisals took place on a yearly basis and inspectors saw that this included discussion around possible additional training requirements.

Judgment:

Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The design and layout of the centre was in line with the statement of purpose. The premises were laid out over two floors and could accommodate 60 residents. Overall, the premises were in good repair with some minor upgrades required. For example, two drawers in a wardrobe in a shared room were broken and required repair. On the date of inspection, the centre was clean and free from odour, warm and well lit.

Whilst there was signage in the centre identifying different wings and areas, some of the signage wasn't obvious as it placed high above the door leading into the specific area. The person in charge stated that this had been identified as an area requiring improvement, that the signage in the centre was under review and additional signage had been ordered which included pictorial signage to assist residents with a dementia. The person in charge stated that although bathroom/toilet doors were not painted a contrasting colour this was under review also. Some murals had been added to the upstairs circulation area which depicted a village scenscape. Halloween decorations had been hung in communal areas. Photographs of residents were displayed throughout the corridors of the centre.

The upstairs dining room lacked homely features, it consisted of dining tables, chairs and a mirror on one wall but otherwise was free from any further homely touches. There was adequate private and communal spaces and a separate visitors' room should a resident wish to meet with family or friends in private.

All bedrooms had either a full ensuite shower, toilet and wash hand basin or a toilet and wash hand basin. Shared bedrooms had adequate privacy screening. Bedrooms were seen to be personalised with residents' belongings such as: blankets and photographs. There was adequate space for storage of belongings. Call bells were within reach of residents remaining in their bedrooms as demonstrated by a resident who spoke with inspectors. Grab rails were in place as required and an elevator operated between the ground and first floor. Residents had access to a well maintained external space and there was a balcony space on the upper floor also.

There was access to equipment to assist residents to mobilise and this was observed to be utilised by staff and stored safely throughout the course of inspection.

Judgment:

Substantially Compliant

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

Safe care and support

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

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

Findings:

This outcome was not inspected against other than to follow up on actions required from the previous inspection.

It was noted at the previous inspection that although a recent internal audit had found that there was a shortage of ski sheets to support the evacuation of immobile residents in an emergency, there was no evidence that these were being sourced. Inspectors saw that this had been addressed. Staff spoken with confirmed that these were now in place and inspectors saw that ski sheets were in place in the sample of beds checked.

It was also noted at the previous inspection that a fire door was inappropriately held open. This had been addressed and inspectors saw that additional equipment was in place to ensure that doors would close in the event of a fire.

It was noted at the previous inspection that the records maintained in relation to fire drills was inadequate. Inspectors found that this was still the case. Fire drills were completed on a regular basis. However inspectors saw that although records now contained the list of staff that attended they still did not record details such as the response time or any learning from the drills.

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:

Gemma O'Flynn
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:	Waterford Nursing Home
Centre ID:	OSV-0000255
Date of inspection:	17/10/2016
Date of response:	14/11/2016

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 were not in place for all identified matters or did not fully guide care and practices. For example:

A resident with diabetes did not have an associated care plan.

A discharge care plan had not been created for a resident, despite there being a plan in place for a resident to be transferred.

An end of life care plan was not in place for all residents in the sample of files reviewed.

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

Wound care plans lacked sufficient detail to consistently guide care, for example, the frequency of recording measures such as photography or wound measurements.

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:

A review of all care plans is in progress. The care plans will include the planned management of each individual resident's health and social care needs, including the individualised management plans of medical conditions such as diabetes.

Plans for discharge or transfer of any resident will be clearly documented.

The PIC will consult residents and their families as appropriate to agree suitable end of life care plans, based on the wishes and preferences of the resident.

Wound care plans are being reviewed. Wounds will be measured and photographed according to the documented care plan; wound assessments will be reviewed and updated each time the wound dressings are renewed.

Proposed Timescale: 31/12/2016

Theme:

Safe care and support

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

Inspectors formed the judgment that the pre-assessment process was not sufficiently robust to adequately identify the resources required for prospective residents.

2. 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:

Prior to admission of any residents to the centre, a comprehensive assessment will be carried out by the PIC, who will consider whether the centre can satisfactorily meet the assessed care needs of the resident as well as the potential impact of the admission on other residents in the centre.

Proposed Timescale: 14/11/2016

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement

in the following respect:

Where a medical professional had advised that a speech and language referral was required, it was evident that the referral had not been instigated. There was no documented rationale for this omission.

3. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

Referrals have been documented for all residents who require specialist referrals to allied healthcare professionals. The PIC and ADON will monitor all residents who require such referrals and will ensure that the specialists' recommendations are documented in the care plan, implemented and evaluated appropriately. The above referral has now been processed.

Proposed Timescale: 14/11/2016

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:

Vetting disclosures were not in place for all staff or volunteers working with residents in the centre.

4. 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:

Garda Vetting disclosures are in place for all staff working with residents in the centre.

Proposed Timescale: 14/11/2016

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 was limited opportunities for residents to participate in activities in accordance with their interests and capacities.

A number of residents remained in their bedrooms throughout the day of the inspection. Inspectors observed very limited staff interaction with these residents and residents told inspectors that staff didn't have the time to sit and chat with them.

Inspectors saw that although staff had received training in a therapy with a focus on promoting communication, especially for people with dementia) sessions were no longer held on a regular basis. Similar issues were noted with a therapy used to improve and maintain memory function. Staff spoken with said that they did not have sufficient uninterrupted time to run these sessions.

5. Action Required:

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

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

The PIC has reviewed the role and function of the Activity Coordinator to ensure that a variety of meaningful activities is offered to the residents, based on their individual choices and preferences.

The staff roster has been reviewed to ensure that there are sufficient staff available to meet the care needs of residents. This will facilitate the Activity Coordinator to schedule appropriate person-centred activities for residents more effectively.

Proposed Timescale: 14/12/2016

Theme:

Person-centred care and support

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

There was limited evidence that residents with dementia were included at the residents' committee or if alternative arrangements were in place to ensure that they were consulted as regards the organisation of the centre.

6. 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:

Residents are invited and encouraged to take part in the resident's meetings. Residents with Dementia will be represented by a family member or an advocate. Regular residents' meetings will be scheduled to ensure residents' consultation and participation in the day to day running of the centre. There was a residents meeting on 20th October 2016 and the next meeting has been scheduled for the first week of December.

Proposed Timescale: 20/10/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

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

A review of staffing levels was required to ensure that there was sufficient staff on duty 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:

A review of staffing levels was undertaken. There are now sufficient staff in place at all times to meet the assessed care needs of the residents, based on the number and dependency levels of the residents and the geographical layout of the centre.

Proposed Timescale: 14/11/2016

Theme:
Workforce

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

Two of four staff files reviewed did not contain a satisfactory history of gaps in employment.

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 employment gaps have been identified and files will be updated to accurately reflect this.

Proposed Timescale: 30/11/2016

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:

Further improvements in the design and decor were required to assist residents with a dementia. For example:
Bathroom doors were not painted a contrasting colour.
Signage throughout the centre required review to ensure it was easily visible and appropriate to all residents.
Some areas lacked a homely features, for example, the upstairs dining room.
Some minor decorative upgrade was required.

9. 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:

There is a plan in place to enhance the environment for residents with dementia. Improved signage will be added and the homely atmosphere will be addressed.

Proposed Timescale: 31/03/2017

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

Inadequate records of fire drills were maintained.

10. Action Required:

Under Regulation 28(1)(c)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

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

Fire Drill records will be improved to include a more detailed description of the fire drill, participants, staff response time and learning outcomes/recommendations.

Proposed Timescale: 31/12/2016

