

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Brymore House
Centre ID:	OSV-0000120
Centre address:	Thormanby Road, Howth, Co. Dublin.
Telephone number:	01 832 6244
Email address:	brymorehouse@gmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Brymore House Nursing Home Limited
Provider Nominee:	Nicola Taylor
Lead inspector:	Sheila McKeivitt
Support inspector(s):	Ann Wallace
Type of inspection	Announced
Number of residents on the date of inspection:	25
Number of vacancies on the date of inspection:	11

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.

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 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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
13 March 2017 09:30	13 March 2017 17:30
14 March 2017 09:30	14 March 2017 16:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Substantially Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This report sets out the findings of an announced inspection. The inspection was carry out in response to the provider's application to renew the certificate of registration that is to care for a maximum 38 residents.

There were 25 residents residing in the centre at the time of inspection with two in hospital and there were 11 vacancies. As part of the inspection, two inspectors met with residents, visitors and staff members. Inspectors observed practices and reviewed documentation such as care plans, accidents and incident forms, medical and nursing records, policies and staff files. The feedback from residents and relatives was extremely positive. The centre was described as a warm, open and welcoming local nursing home.

Inspectors found that actions identified on the last inspection had been addressed. Improvements were identified in safe and safe guarding as the use of bed rails as a

form of restraint had been significantly reduced. The standard of nursing care plans had improved. Each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care. There was a wide variety of activities for residents' to participate in. However inspectors found that governance of the centre required improvement. Fire prevention issues identified in June 2016 had not been addressed and no quality annual review was not available for review. The premises required improvement to ensure that each resident had an adequate amount of private accommodation/space to carry out activities in private.

The action plan at the end of the report identifies those areas where improvements are required in order to comply with the regulations.

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 Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A statement of purpose dated November 2016 was submitted to HIQA with the application to renew registration. It reflected the services available to residents. However, it did not accurately reflect the make-up of the bedrooms within the centre, the number of beds outlined in pages 21 and 23 added up to 37 beds, and the centre is registered for 38 beds. Inspectors noted that single room 22C was not included. The organisational structure required review on page 20 as it referred to two assistant directors of nursing; however one had left the post of assistant director of nursing and was now working as a staff nurse.

A copy of the statement of purpose was available to residents. Inspector saw a copy on display in the front foyer of the centre.

Judgment:

Substantially Compliant

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:

There was a clearly defined management structure. It included the provider, person in charge and one assistant director of nursing. Inspectors found the governance of the centre was not strong enough to ensure compliance with the Health Act 2007.

The provider worked full-time between her two centres, the person in charge (PIC) and assistant director of nursing (ADON) worked full-time in Brymore House. There had been one change to the management structure since the last inspection, one of the two assistant directors of nursing had reduced her hours and was no longer held the role of assistant director of nursing. Inspectors were informed that the provider visited the centre daily and spoke with the person in charge and assistant director of nursing regarding the management of the centre. There was no evidence that the management team were meeting on a regular, consistent basis to formally discuss management issues. Inspectors found that the lack of management team meetings meant that a number of governance issues had not been addressed for some period of time. These included:

- fire management issues (outlined in detail under outcome 8).
- no annual review completed and quality Improvement plan available for review.

The ADON was the named person to take over in the absence of the person in charge. She is a registered general nurse having completed a professional certificate in nursing (care of older persons in a residential setting). She had significant experience in carrying for older persons in a residential setting having worked in the centre since 2007.

The PIC was auditing in areas of practice such as the use of bedrails, accident and incident and falls, contracts of care, nursing documentation, development of pressure ulcers (there were none), staff files and complaints. The results of these audits were clearly analysed, and communicated to staff at handover and at staff meetings. Where action plans were included there was evidence that these actions had been addressed or were in the process of being addressed.

An annual review of the quality and safety of care delivered to residents had not been completed for 2015 and 2016. Resident surveys had been issued in April 2016 and analysed in June 2016. Inspectors were informed that 30 questionnaires were sent out to residents or their next of kin where they did not have capacity to complete. The provider informed inspectors verbally of the quality improvement plan for 2017.

Judgment:

Non Compliant - Moderate

***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:

Inspectors found the records listed in schedules 2, 3 and 4 of the regulations were maintained in a manner to ensure completeness, accuracy and ease of retrieval.

The centre had all operational policies as per schedule 5 of the regulations. However, the policies did not include a development, implementation or review date. They had been reviewed each year by the person in charge however these reviews resulted in few changes over the past seven years. Overall, they were basic policy and did not reflect all practices in the centre. For example the provision of information to residents' did not refer to residents' meeting or satisfaction surveys.

The centre did not have a health and safety statement in place.

Inspectors reviewed a sample of residents' records. They contained all of the health and medical information as listed in schedule 3. The directory of residents contained all of the information required in schedule 3.

All other records as per schedule 4 were maintained and readily available. The centre had insurance in place.

A sample of four staff files reviewed were found to contain all the requirements as per schedule 2 of the regulations.

Judgment:

Substantially 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:

Measures to protect residents being harmed or suffering abuse were in place.

Residents spoken with stated they felt safe in the centre. There was a policy and procedures in place for the prevention, detection and response to abuse. It provided guidance for staff if a member of the management team were involved in an alleged incident. Staff spoken with demonstrated a good knowledge of what constituted abuse and they all confirmed they had up-to-date refresher training in place. The provider told inspectors that all staff had a vetting disclosure in place in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. Inspectors saw evidence of this in the staff files reviewed.

No monies or pensions were managed on behalf of residents. Residents were encouraged and facilitated to take control of their own petty cash. They were provided with a lockable space in their private bedroom.

Residents with dementia displaying behaviours that may challenge had a corresponding behavioural support plan in place and all incidents of behaviours that challenge were being recorded and reported to the resident's general practitioner.

There was a significant reduction in the use of restraint in the centre since the last inspection and this was reflected in the last quarterly return submitted to the Authority. Where bedrails were in use there was a record of alternatives trialed, tested and failed prior to bedrails being used. Residents with bedrails in use also had a care plan in place to reflect their use.

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:

Inspectors had concerns that the health and safety of residents, staff and visitors to the centre was not promoted. The provider had not taken adequate precautions to protect residents to protect residents against fire.

The centre had a risk management policy in place. The policy outlined the procedure for identifying and assessing risks in the centre. It also outlined the measures that can be put in place to mitigate risk. The risk register identified some risks in the centre. The risks contained information on actions and additional actions taken following the initial

assessment in order to control or mitigate the risks. Inspectors identified a number of risks which were not recorded in the risk register although the provider and person in charge were aware of these risks. These included:

- Fire doors in protected corridors not upgraded with cold smoke seals (this had been reported in a report completed following an inspection by a fire prevention officers in June 2016).
- Bedrooms doors were being held open with door stoppers.
- Missing caps off radiator ends leaving sharp edges exposed.
- Fire doors in protected corridors not upgraded with cold smoke seals as per assistant fire. Prevention officers' report dated 12 June 2016.
- Use of extension lead in an occupied bedroom.
- The viewing of residents in the top sitting area on a screen visible to everyone in the middle sitting. This was removed by the provider immediately post discussion with inspectors regarding their concerns on infringing of residents privacy.
- The storage of flammable items in the electric/switchboard cupboard. This cupboard was cleared of all items by the provider following a discussion around the risk associated with the practice.

Fire procedures were clearly displayed in the centre and the evacuation route was clearly marked in all areas. Inspectors observed that there was a sufficient number of fires fighting equipment throughout the centre and it was serviced annually. Inspectors reviewed the records of the fire alarm, emergency lighting which was serviced on a quarterly basis in 2016 and 2017. Daily visual checks of equipment and fire doors were being taken by staff and recorded. A fire prevention officers report from July 2014 had raised concerns about fire doors not being closed. Inspectors observed that a number of fire doors were wedged open on the first day of inspection and the risk associated with this practice was brought to the attention of the provider and person in charge. On day two of the inspection the inspector observed the same practice and again brought it to the attention of the provider and person in charge. All fire doors were closed prior to inspectors leaving the centre on day 2 of the inspection. The fire officer visited the centre again in June 2016 the report identified management deficiencies and stated that the fire doors in protected corridors needed to include cold smoke seals. The provider confirmed that this work had not been completed.

All staff had been trained in fire safety within the last year. Drills were taking place on a monthly basis and were being recorded. There was evidence that night staff had been involved in day time fire drills. However, inspectors found that no fire drill had been practiced at night time when there would be a maximum of three staff on duty with responsibility for evacuating residents from the three floors of the centre. Inspectors spoke to a number of staff and they were clear on what action was to be taken in the instance of the fire alarm sounding.

Inspectors reviewed the incidents and accidents in the centre for 2016 and 2017. Each incident was documented and a risk assessment was carried out following any incident or accident, such as a resident falling.

There was an infection control policy in place for the centre. There were sufficient numbers of hand-wash basins and hand sanitiser gels available throughout the centre. Inspectors were informed that rooms were cleaned daily, however it was noted that

some bedrooms require a more in-depth clean as a heavy layer of dust was observed on skirting boards in occupied bedrooms.

The centre had an emergency plan in place in case of the occurrence of a fire, a flood, a gas leak, power outage, water loss and other possible scenarios. These plans were detailed and had sourced alternative areas to move residents to if a full evacuation of the centre was required. The centre did not have a health and safety statement in place (this is actioned under outcome 5).

Judgment:
Non Compliant - Major

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:
Inspectors saw that there was a medication management policy in place which gave appropriate guidance to staff. Inspectors reviewed the prescription records and medication administration records for a sample of residents and found that this documentation was completed and maintained in accordance with the centres policies and professional guidelines for the most part. The one issue identified was that medications being administered in a crushed format were not individually signed to be administered as crushed. The prescription contained a overall crushing order on the top of the chart which was not in line with best practice guidelines.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with professional guidelines and the centre's policy. Nurses kept a register of MDAs. The stock balance was checked and signed by two nurses at the time of administration and change of each shift. Inspectors checked the balances and found them to be correct.

Judgment:
Substantially Compliant

Outcome 10: Notification of Incidents
A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe care and support

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

No actions were required from the previous inspection.

Findings:

A record was kept of all accidents and incidents which occurred in the centre. Those which were required to be notified to HIQA had been reported within the recommended time frame.

Judgment:

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):

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

Findings:

Each resident's wellbeing and welfare was maintained by a high standard of evidence-based nursing care.

Inspectors saw evidence that residents received appropriate medical and allied health care without delay. Residents were seen by their GP on a frequent basis and had their medications reviewed. They also had access to an optician, dentist, podiatrist and chiropodist.

Samples of residents' documents were reviewed in detail. Residents had a comprehensive assessment completed on admission and these were reviewed on a four monthly basis. Each need identified on assessment had a care plan in place to reflect this need.

There was a variety of activities for residents to choose from. These included the provision of weekly art therapy, craft therapy and holistic therapy. Activities specifically meeting the needs of residents' with dementia such as imagination gym. Residents' had access to an enclosed secure garden which contained points of interest for residents and seating. Wi-Fi was now available throughout the centre and residents had access to a computer in the communal area.

Judgment:

Compliant

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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 centres reflected description as outlined in the statement of purpose.

Inspectors found the centre to be warm and tidy with good lighting and ventilation, it was suitably decorated and residents spoken with described it as home. Residents had access to a dining room and living rooms on the ground middle and top floor together with a private room which could be used to meet visitors in private. They could independently access the garden which was furnished appropriate to the needs of residents; the inspectors observed It was a safe and secure space.

The single and twin rooms had adequate space for manoeuvring equipment and space for furniture to meet residents' needs. However, one twin room and one single room (both currently unoccupied) had little sunlight entering through the windows as the windows were positioned opposite and within close proximity to a wall of high footage. Two single rooms, one on the middle floor (which was currently occupied) and one on the top floor (unoccupied) did not provide for an adequate amount of private space.

Inspectors saw that the remaining six, twin bedrooms needed to be reconfigured to ensure they provided for an adequate amount of private accommodation/space for both residents to include access to their personal storage facilities. The screening in all the twin bedrooms did not ensure the privacy of residents for example in room 19, 22, 28 and room 3. Inspectors observed that room 3 was a small room and was currently being used as a single bedroom. The storage facilities (wardrobes) available to residents occupying bedrooms 5 and 6 were positioned outside their bedroom doors on the corridor, this required review.

There was only one cleaning room which inspectors were told was used by both kitchen and household staff. This was not in line with best practice. There was a lack of storage for equipment, inspectors saw a large amount of equipment being stored in the one sluice room in the centre. Staff had no nurses station or office available to them they were working from a space located under a stair well.

There were an adequate number of toilets and bathrooms to meet the needs of residents. However, the signage on bathroom doors required review and some had no

handrails in place by the toilet, shower and/or wash-hand basin.

Post the inspection the provider submitted a proposed plan which reflected reducing bed numbers in order to provide for additional storage cleaning and office space. These changes would be completed through internal reconfiguration of rooms.

Judgment:

Non Compliant - Moderate

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The policy and practice in place ensured that each resident received care at the end of their life which met their physical, emotional, social, psychological and spiritual needs and respected their privacy, dignity and autonomy.

Inspectors reviewed a random sample of three residents' files. Residents had their end-of-life preferences identified within their comprehensive assessment but these were detailed enough to ensure staff could implement these preferences at the end of one's life. Each resident had a detailed person centred end-of-life care plan in place. The plan of care had been discussed with the resident prior to their condition deteriorating and was detailed enough to direct end-of-life care. All religious and cultural practices were facilitated.

The centre had access to a palliative care team and there was no delay in seeking their expert advice.

Judgment:

Compliant

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:

Inspectors saw that the nutritional needs of residents were being met. There was a nutritional and hydration policy in place.

Inspectors observed residents being served lunch during the inspection. Residents had a choice offered to them. The dining experience observed appeared to be a nice relaxing and social event for residents. Staff were available to assist those who required assistance and provide it in a discreet manner. Inspectors noted that residents' independence was promoted. Inspectors saw residents had access to fresh fruit, biscuits, cakes and hot drinks between meals. They had access to fresh drinking water at all times. A variety of juices, water and milk was provided with lunch

Inspectors met the chef on duty and was informed that there was a choice of meals offered at each meal time. In the kitchen the chef held a list of residents' names, their preferred foods, the consistency of diets prescribed for them and it identified those on special diets. This list was updated monthly by nursing staff or when there was a change in the residents' admitted or their status.

The person in charge had a system in place for monitoring and reviewing residents' weights on a monthly and Malnutrition Universal Screening Tool (MUST). Those identified as at risk of malnutrition were referred without delay to a dietician.

Judgment:

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:

There were appropriate staff numbers and skill mix to meet the assessed needs of

residents and for the size and layout of the centre.

The majority of staff had worked in the centre for a long period of time. There was a extremely low turnover of staff. Therefore they knew the residents and their families well. Inspectors observed staff promoting residents independence when mobilising, eating and participating in activities.

Staff had up-to-date mandatory training in place. They also have access to other education and training to meet the needs of residents. This was provided in-house by the pro-active person in charge and included topics such as the assisted decision making capacity Act 2015 and on meeting the nutritional needs of residents. Education was also provided to residents on topics such as dementia.

There were effective recruitment procedures in place. A four staff files were reviewed they contained all the required documents outlined in schedule 2. All qualified staff named on the staff roster had up-to-date registration with the Nursing and Midwifery Board of Ireland (NMBI) in place. Inspectors saw that the person in charge had formal supervisory meetings with staff at least once per year.

A selection of volunteers files reviewed showed they had their roles and responsibilities outlined and were vetted in accordance with best recruitment practice.

Judgment:
Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Sheila McKevitt
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:	Brymore House
Centre ID:	OSV-0000120
Date of inspection:	13/03/2017
Date of response:	21/04/2017

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

There was no evidence that the management team met or had plans to meet on a regular consistent basis in 2017.

1. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and

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

details responsibilities for all areas of service provision.

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

A full calendar of meeting have ben scheduled for 2017 to include all management team members

Proposed Timescale: 30/03/2017

Theme:

Governance, Leadership and Management

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

No annual review had been conducted for 2015 or 2016.

2. Action Required:

Under Regulation 23(d) you are required to: Ensure there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.

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

Annual reviews have been retrospectively completed using data collected from audits during 2015 / 16. A copy of these have been sent to the Chief Inspector.

Proposed Timescale: 30/03/2017

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:

All policies required review to ensure they reflected practice.

They required a date for development, implementation and review and required signing.

The centre did not have a health and safety statement in place.

3. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

All policies now include an implementation date, review & Improvement section. We will

review all policies over the coming months to ensure they are reflective of practice & regulatory requirements.
We have a comprehensive Health & Safety Manual in operation & will develop a statement reflective of & referring to all Health & Safety matters

Proposed Timescale: 30/05/2017

Outcome 08: 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:

The risk register did not include all risks identified in the centre.

4. Action Required:

Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

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

A new risk register has been designed to allow for all risks to be identified & remedied. Staff have been educated in the importance of identifying daily risks. Premises walk about's have commenced on a monthly basis by 2 people to aid in identifying risks

Proposed Timescale: 30/03/2017

Theme:

Safe care and support

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

Fire doors in protected corridors had not been upgraded with cold smoke seals as per a fire prevention officers report dated June 2016.

Bedrooms doors were held open with door stoppers although identified as a deficiency in a fire prevention officers report dated July 2014.

5. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

All doors have always been fitted with Intumescent smoke seals , these are situated in the frame of the doors & are white in colour, we have replaced these seals to brown so that they are clearly visible. We have contacted the fire officer to arrange another visit to clarify the position regarding the presence of smoke seals in door frames or doors.

Door guards have been fitted to the bedroom doors which allow for residents have their doors ajar, & these will release automatically to allow doors to close on activation of the fire alarm. All other doors remain closed at all times.

Proposed Timescale: 30/04/2017

Theme:

Safe care and support

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

A fire drill had not been practiced at night when staffing levels were reduced to three.

6. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

All staff including night staff have attended fire training & fire drills & we have now conducted extra training & drills with all night staff.

Proposed Timescale: 30/04/2017

Outcome 09: Medication Management

Theme:

Safe care and support

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

Medications being administered in a crushed format did not have an individual crushing order.

7. 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:

An individual crushing order has been put in place for all crushed medication & our policy amended to reflect this.

Proposed Timescale: 15/04/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

Matters relating to Premises as outlined in Outcome 12 included:

The screening in some twin bedrooms did not ensure the privacy of residents for example in room 19, 22, 28 and room 3.

There was only one cleaning room which was used by kitchen and household staff. Staff had no nurses' station or office available to them.

Bathrooms required review for signage and handrails were required in a number of areas.

The storage facilities available outside room 5 and 6 required review.

Two single rooms 1A and 22C did not provide adequate private accommodation/space for residents.

There was not enough storage space for equipment.

8. 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:

The screening in rooms 22 & 28 will be configured to ensure more privacy for both residents,

In relation to room 3, this is now a single room & will have necessary work completed once it becomes vacant.

Room 19 will have remedial work carried out on the central partition once it becomes vacant. This will ensure more privacy for both residents.

The Kitchen now has a separate cleaning room with all necessary requisites. (Complete)

A new Nurses office has been identified & is in full operation. (Complete)

New pictorial signage has been ordered for the bathrooms & extra handrails placed where needed.

We are reviewing the storage arrangement for rooms 5 & 6.

Room 1A will be extended to 13.4 sqm (by July 17) & room 22c is now decommissioned & being turned into a residents sensory room.

A large storage has been identified on the ground floor & is in full operation. (Complete)

Proposed Timescale: 31/07/2017

