

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Blainroe Lodge
Centre ID:	OSV-0000016
Centre address:	Coast Road, Blainroe, Wicklow.
Telephone number:	0404 60030
Email address:	blainroe@firstcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Firstcare Ireland (Blainroe) Limited
Provider Nominee:	John O'Donnell
Lead inspector:	Deirdre Byrne
Support inspector(s):	Sheila McKeivitt
Type of inspection	Unannounced
Number of residents on the date of inspection:	69
Number of vacancies on the date of inspection:	2

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 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 10:00 To: 26 July 2016 18:30

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 05: Documentation to be kept at a designated centre	Non Compliant - Moderate
Outcome 07: Safeguarding and Safety	Substantially Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Substantially Compliant
Outcome 11: Health and Social Care Needs	Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 15: Food and Nutrition	Non Compliant - Moderate
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an unannounced inspection by the Health Information and Quality Authority (HIQA). The purpose of the inspection was to follow up on matters arising from a monitoring inspection that was carried out on the 5 January 2016 and to monitor progress on the actions required. This inspection also considered unsolicited information brought to the attention of HIQA.

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

Inspectors found that the provider had made some progress in improving 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. Specifically improvements in compliance with Outcomes 7 and 9 (safeguarding and safety of residents and medicine management) were identified.

However, adequate improvements in compliance were not identified under Outcomes 2, 5, 8 and 18 (governance and management, documentation to be kept at a designated centre, health and safety, risk management and suitable staffing). Previous findings of moderate non-compliance in relation to these Outcomes remained unchanged seven months post the last inspection.

- Outcome 2; Governance and management: issues identified related to the accountability of senior staff and the standard of auditing.
- Outcome 5; Documentation to be kept at the designated centre: care plans did not reflect the care being delivered.
- Outcome 8; Health, safety and risk: fire safety procedures were not in line with best practice.
- Outcome 18; Suitable staffing: nursing staff skill mix did not meet the assessed needs of residents in the centre and while a staff review had taken place, there was no documented evidence that the review had considered the size and layout of the designated centre.

In addition to the above inspectors also found that further improvements were required in relation to the implementation of the national restraint policy, Towards a Restraint Free Environment in Nursing Homes (2011).

On a positive note there were systems in place to document residents' medical and general records and inspectors found that the provider ensured the complaints procedures were actively implemented in the centre.

The action plans at the end of this report identify where improvements are required to meet the requirement of the regulations and standards. The provider submitted two versions of an action plan response but neither fully addressed the non compliance regarding the containment of fire in Outcome 8, and therefore the action plan response was not accepted by HIQA

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):

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

Findings:

There were two actions from the previous inspection in respect of the management structure, accountability of the management team and the management systems to ensure that the service provided is consistent and effectively monitored. Neither of these issues had been addressed in full, although the latter of these remained within the proposed timescale set by the provider.

The designated centre is operated by the Firstcare Ireland (Blainroe) Limited. There was a clearly defined senior management team that included the person nominated on behalf of the provider and senior management which met every month. However this structure required improvement as evidenced by the findings reported under Outcomes 15 (food and nutrition) and 18 (staffing). This was discussed in detail with the person in charge and the provider at the feedback meeting and they outlined the actions they were taking to enhance the day to day management of the centre.

Inspectors found that the provider continued to implement a system to monitor the quality of safety and care provided to residents in the centre. Audits completed in 2016 included audits of care plans, medication management, tissue viability, call bell responses, accidents and incidents. An operational report submitted by the person in charge to the senior management team each month provided a brief overview of audits. However these audits lacked identified action plans, timescales and assigned accountability. Therefore it was not evident what actions had been taken and who was responsible for improving the quality of life of residents in the centre. This action remained within the proposed time scaled set by the provider of 31 December 2016. For example a staffing review did not consider the size and layout of the centre as outlined in Outcome 18 (workforce) and there was no evidence that this review had considered the impact of an adequate staff skill mix during the day on the care of residents or the

completion of care plans.

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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):

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

Findings:

There had been some improvements in the standard of documentation held in the centre since the last inspection. Examples included

1. Records of medication management as detailed in Schedule 3 of the regulations were satisfactory.
2. The temperature of the medicine storage fridge was measured and documented daily. Nutritional supplements that required refrigeration were stored in a refrigerator.
3. The allergy section of the prescription sheet was completed for all residents to include information on any known allergies to medicines or if there were no known drug allergies (NKDA).
4. Medication administration record sheets included documented explanations if medication had not been administered as prescribed.
5. Policies and procedures relating to medication as required by Schedule 5 were now appropriately implemented in practice.

Findings of non compliance on this inspection related to care plan documentation, behavioural support plans and restrictive practices. The documentation of care plans for the management of unintentional weight loss required improvement. For example, food records were not completed for a resident who had swallowing difficulties and who had lost weight. The staff were familiar with the residents' nutritional needs, and there was evidence of action taken to support residents. However, the care to be delivered was not outlined in sufficient detail in the residents' care plan and could lead to a potential choking risk for the resident.

The documentation of specific behavioural support plans for residents' with responsive behaviours had been partially addressed, with further areas of improvement identified. A sample of care plans read did not clearly describe the residents' behaviours, the triggers to the behaviours, the type of medicines if prescribed to manage the behaviours and when to administer these medicines.

Alternatives to the use of bed rails was not consistently documented in assessments in residents' files as detailed in Outcome 7.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

Actions from the previous inspection were in progress and due for completion by 31 December 2016.

Inspectors found that the provider had put in place reasonable measures to safeguard residents and protect them from abuse. The policy on the protection and prevention of abuse had been reviewed at the last inspection and guided practice. Since the last inspection, there had been incidents of suspected abuse in the centre that required notification to HIQA. There was evidence that action had been taken, that the person in charge had carried out investigations into the incidents and families were informed of allegations of abuse.

Inspectors spoke with staff who knew what action to take if they witnessed, suspected or received a disclosure of abuse. They also explained what they would do if they were concerned about a colleagues behaviour. New staff who had started work in the centre had attended training in the protection of vulnerable adults as part of their induction. The training was facilitated by the person in charge who had completed a train the trainer course.

The national policy Towards a Restraint Free Environment in Nursing Homes (2011) was

in the process of being implemented in the centre. Care plans were developed to support the use of restrictive practices and consent was obtained from residents where possible or consultation took place with representatives. Records viewed by inspectors indicated that there were 12 fewer residents using bedrails since the last inspection. The person in charge attributed this reduction to regular review and discussion with the residents.

However there was an inconsistent approach to the recording of alternatives to restrictive practices. For example, the alternatives to the use of physical restraint such as bedrails were not consistently documented in all residents' files. In addition, the assessment tool did not reflect the requirements of the national policy regarding alternatives.

A small number of residents presented with responsive behaviours in the centre. There were policies in place to provide guidance to staff on managing responsive behaviours. Training in the management of responsive behaviours and a number of staff members had completed the training since the last inspection of January 2016.

Other measures in place to enhance the safety of residents included day time receptionist staff, secure entrance and exit points from the centre and a visitors which all persons attending the centre to visit or work were required to sign on arrival and exit from the centre.

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

Findings:
Previously identified risks associated with the storage of oxygen cylinders had been addressed. Cylinders were locked on moveable trolleys in secure well ventilated areas accessible to nursing staff as required. However the risk register had yet to be updated to reflect the amended controls for the safe storage of the oxygen cylinders.

Inspectors observed that the ability of residents to mobilise independently was impaired by items hanging off hand rails which blocked residents' access to the handrails.

Inspectors reviewed the practice of monitoring blood glucose levels of residents with

diabetes. Good practices were observed in relation to this area as residents who had diabetes and required blood monitoring were provided with their own blood glucose meter with their own individually labelled lancing device and single use safety lancets.

The actions from the previous inspection regarding the cleanliness of the centre were in progress, with some further improvements required. The centre was regularly cleaned by a team of housekeeping staff, to a good standard of cleanliness. The communal areas and bedrooms were generally found to be clean. A stand alone cleaner's room on the ground floor was inspected and the standard of hygiene was adequate. However, the standard of hygiene of a catering trolley used to transport meals to dining rooms was not satisfactory. The trolley was observed to be unclean with old food debris on the surfaces and handles. This was brought to the catering staff and management's attention.

The precautions in place against the risk of fire in the centre required improvement. During the course of an inspection last January the practice of wedging fire doors was identified as a non-compliance. The providers action plan stated that an external consultant had been contacted in relation to appropriate arrangements around resident's bedroom doors and that the issue would be addressed by the 30 June 2016. However no improvements had been carried out by the date of this inspection. The

During this inspection, inspectors found that ten residents' self-closing bedroom doors were wedged or held open with furniture on the ground floor. Inspectors brought this matter to the attention of the person in charge and the provider. They stated they were in the process of reviewing the bedroom fire doors, yet no other information was provided.

Staff who spoke with inspectors on the day of the inspection had up to date training and were clear on the actions to take in the event of fire. Emergency lighting, alarm and fire fighting equipment were in place and maintained in all parts of the designated centre.

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

Findings:
Inspectors reviewed the actions from the previous inspection regarding the practices

and documentation in place relating to medication management in the centre.

The centre had operational policies relating to the ordering, prescribing, storage and administration of medicines. All medicines were stored securely within the centre, and a fridge was available for all medicines or prescribed nutritional supplements that required refrigeration, and the temperature of this fridge was monitored.

The inspectors reviewed the processes in place for administration of medicines, and were satisfied that nurses were knowledgeable regarding residents' individual medicine requirements and followed professional guidelines. Nursing staff were observed to safely administer medicines. There were procedures in place for the handling and disposal of unused and out of date medicines.

There were systems in place within the centre for reviewing and monitoring medication management practices, including monthly audits of the prescribing, administration records and storage of medicines within the centre. Medication incidents including medication errors were recorded and reviewed within the centre. There had been no medication incidents or errors since the last inspection.

Two areas of medication management required attention:

- Nursing staff were administering medication to residents in crushed form although it had not been specifically indicated for each medication on the prescription chart.

-The prescribed frequency and timing of administration was not clearly indicated on the prescription sheet for all medicines

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:

Overall, the inspectors found good practice in ensuring the healthcare needs of residents were met. Each residents well being and welfare was maintained to a good standard of

evidence based care (nursing, medical and allied healthcare)

However, as outlined in Outcome 5 of this report further work is required to meet the Schedule 3 requirements of the Regulations. The completion of care plans for residents who had experienced weight loss did not guide practice and did not outline the interventions to be carried out to mitigate further risks to residents.

Judgment:
Compliant

Outcome 13: Complaints procedures

The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

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

Findings:

Findings from the previous inspection was addressed. The provider demonstrated a positive attitude towards complaints. There was a policy and procedure that guided the management of complaints in the centre.

The complaints procedure was displayed in the reception area and it included an appeals process if complainants were unhappy with the outcome. There was good oversight of the documentation and response to complaints by the operations manager.

All complaints were logged and investigated by the complaints officer (the person in charge). The inspector read a sample of complaints and there was evidence of the action taken, outcome, and a record of the complainant's level of satisfaction. It was clear there was a timely response to all complaints received.

The residents and relatives told the inspector they could talk to the person in charge if they had any complaints.

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 found residents were provided with meals that were freshly prepared in quantities in accordance to their assessed needs and dietary requirements. There was a range of choice and variety available to residents. However, this choice of meals was not offered to all residents. Furthermore, communication between the catering staff and kitchen staff on the most up-date dietary requirements of residents required improvement so that staff are aware of the nutritional status and therapeutic dietary requirement for each resident.

Residents each had a malnutrition risk screening tool (MUST) completed on admission and this was reviewed on a monthly basis. Residents were also weighed and had their body mass index (BMI) completed on a monthly basis. Those with nutritional care needs had a care plan in place and those identified as at risk of malnutrition were referred to a dietician where required. Inspectors saw that residents' likes, dislikes and special diets were all recorded.

There were systems in place to communicate this information with the catering staff but these systems were not effective. The inspector viewed a list of residents and their specific dietary requirements. However, it was dated January 2016, and did not contain information on residents who had been recently admitted to the centre. In addition, the information was not comprehensive enough to guide the catering staff. For example, kitchen staff confirmed that there was no information on residents with diabetes or residents who required meals to be fortified by kitchen staff.

There was an inconsistent approach to the delivery of meals across the centre. Residents on the ground floor, had a choice of two different options at each meal time while residents on the first floor were not offered such a choice. On the first floor, a menu was displayed on a piece of white paper on the wall outlining the variety of choice at each meal. However such a menu was not accessible to residents who needed assistance to mobilise or who preferred to have their meal in their bedroom. This was confirmed by one resident. Improvements are required to ensure that all residents are consistently offered a choice of meals. This was discussed with the catering staff during the inspection and at the feedback meeting.

Residents who required meals and drinks prepared to a certain consistency had them served as reflected in their assessment. There were some residents who required support at mealtimes and they were provided with timely assistance from staff, in a discreet and respectful, calm and professional manner. The meals looked wholesome and smelled very appetising and some residents told the inspector they enjoyed their lunchtime meal. Nursing staff did not supervise mealtimes in the dining rooms.

There was fresh water, juices and milk available to residents at mealtimes. During the day residents were offered a variety of fresh fruit, snacks and refreshments.

Judgment:

Non Compliant - Moderate

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):

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

Findings:

The January 2016 inspection identified a requirement for

1. A staffing review that took account of the size and layout of the premises not being fully reviewed
2. Training in the use of psychotropic medicine.

This inspection found that the requirement to review staffing against the size and layout of the centre had not been addressed. An adequate nursing staff skill mix to meet the assessed needs of residents was not evident during this inspection. Discussions with the person in charge and a review of the staff roster confirmed that there were two nurses on duty from 8am to 8pm. This level of staffing was insufficient to meet the needs of 69 residents of whom 50% had a high to maximum dependency level, and approximately 80% had a dementia, cognitive impairment or a psychiatric diagnosis.

Consequences of the staffing model included the following:

- Nursing staff were not available to supervise residents who required modified consistency diets during mealtimes,
- There was no system of supervision of residents assessed as high to maximum dependency in communal areas during the inspection,
- There was no nursing staff available to ensure a timely response to a resident who required assistance when becoming unwell. A nurse in one unit had to leave a medicine round to attend to a resident who became ill,
- There were deficits identified in the documentation of residents care plans,

- Residents' most up-to-date dietary requirements were not being communicated to the kitchen staff.

The person in charge acknowledged that the nursing staff skill mix was not adequate. There were plans to recruit more nursing staff and as more nurses accepted posts, the staff skill mix would be increased.

A number of agency staff were required to cover staff shifts in the event of unexpected leave and shortages in the centre. An agency service level agreement was in place.

There was evidence that staff had access to education and training. The action from the previous inspection regarding the provision of training in the administration of as required medicines (PRN) and on the use of psychotropic medication was completed.

Inspectors reviewed a sample of files and found that nursing staff had up-to-date registration with An Bord Altranais agus Cnáimhseachais na hÉireann (Nursing and Midwifery Board of Ireland).

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
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:	Blainroe Lodge
Centre ID:	OSV-0000016
Date of inspection:	26/07/2016
Date of response:	12/12/2016

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 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The management structure shall be reviewed to ensure appropriate accountability is in place.

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:

Post inspection two Clinical Nurse Managers have been appointed and commenced their new roles on 22nd August. As discussed at the time of inspection an additional nurse from 2pm - 8pm had been allocated to the home. Recruitment for this staff is underway. In the interim additional healthcare assistants x 4 are allocated to the home daily to ensure residents care needs are met. The Operations Team and Home Manager have clearly defined roles and responsibilities in the management of the home. The Home Manager is responsible for the day to day running of their Nursing Home, including but not limited to staffing and staff induction, care provision, safety and safeguarding of residents, complaint management, auditing care practices and care plans and staff training. The Home Manager is assisted by the Clinical Nurse Managers.

The Operations Manager is responsible for supporting, guiding and assisting the home Manager in all aspects of their role. The Compliance and Quality Manager is responsible for all recruitment and HR issues in the Home. They review all documentation prior to usage and are responsible for compliance with HIQA, Fire and HSA. FirstCare have also appointed a Clinical Bed Manager (CBM) for the group to complete all assessments of potential residents. The CBM is now completing the majority of assessments for Blainroe Lodge with minimal support from the Home Manager.

A new Training Co-ordinator has been appointed to the Group also who is solely responsible for all the organising, recording and monitoring of all mandatory and non-mandatory training within the homes.

Proposed Timescale: completed August 30th, 2016

Proposed Timescale: 30/08/2016

Theme:

Governance, Leadership and Management

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

The completion of audits requires improvement. For example, the inclusion of actions, timescales and person responsible, to effect change in the centre.

2. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

The audits used within the Nursing Home are currently under review and will be amended to ensure that all actions required/taken are documented and signed off when completed by the Home Manager or delegated other.

The audits now have an action and learning section which clearly identifies the issues and the actions necessary to ensure compliance as well as the person responsible and the timeframe for completion. Discussions relating to the audits will take place monthly between the Home Manager and Operations Manager. The Operations Manager will feedback this information to the Managing Director and Compliance & Quality Manager at the weekly Governance and Management Meeting and any changes that are required and/or need sanctioning will be communicated to the Home Manager via the Operations Manager.

Proposed Timescale: 30/12/2016

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:

Care plans in place did not contain enough details to fully guide and inform staff implementing care.

3. 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:

Inspectors noted an improvement in care plans within the Nursing Home since the previous inspection. Work will continue on specific care plans over the next 3 months to ensure compliance. The Home Manager and Clinical Nurse Managers will continue to review care plans monthly with staff and put action plans in place to ensure all care plans guide all staff in supporting and providing care for our residents. Blainroe Lodge has in place a named nurse for each resident. Care plans are currently under review by the Home Manager and Clinical Nurse Managers with changes required being discussed and effected immediately. Care Plan training has been arranged for all staff.

Proposed Timescale: 31/03/2017

Outcome 07: Safeguarding and Safety

Theme:

Safe care and support

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

The implementation of the National policy in terms of the consideration of alternatives to restraint requires improvement.

4. Action Required:

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

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

The restraint policy and assessment tool has been reviewed and updated to reflect evidence of alternatives used. This tool will be trialled within the home to ensure it adequately records all alternatives to restraint discussed and/or used and that same are used in accordance with best practice and national policy.

Proposed Timescale: completed October 15th, 2016

Proposed Timescale: 15/10/2016

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:

A number of physical hazards in the environment required review to mitigate risks associated with storage on corridors.

5. Action Required:

Under Regulation 26(1) you are required to: Ensure that the risk management policy set out in Schedule 5 includes all requirements of Regulation 26(1)

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

A risk management review of the environment has taken place. Storage areas have been assessed and associated risks have been removed. Where risks were unable to be removed the storage area was made obsolete and alternative storage sources within the home.

Additional handrails are now in situ to promote independence and safety of all residents in the home. Storage areas have been created to remove potential hazards from the corridor areas.

Hooks and hanging areas have been provided for handling belts and other assistance aids used to assist residents.

Proposed Timescale: completed August 15th, 2016

Proposed Timescale: 15/08/2016

Theme:

Safe care and support

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

Fire doors in residents bedrooms on the ground floor were found to be wedged open.

The arrangements in place to contain fire in the centre require improvement.

6. 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:

The residents doors have been fitted with an opening device that ensures all doors can be maintained in the open position safely without wedging. In the event of the fire alarm activating this device will automatically activate the door closure to ensure safety of the resident in the event of an emergency.

Proposed Timescale: completed October 25th, 2016

Proposed Timescale: 25/10/2016

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:

There were a number of issues that do not conform with appropriate medication management practice:

- where residents required their medicines to be crushed prior to administration the prescriber had not indicated that crushing was authorised for each individual medicine on the prescription sheet.

-the prescribed frequency of administration was not clearly indicated on the prescription sheet for all medicines and in some cases the times of administration were not clearly indicated.

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:

FirstCare have reviewed the Nursing Home Prescription and have amended same to reflect permissions for the crushing of medications and the frequency of administration. All GPs within the Nursing Home will be respectfully requested to use this new Prescription by the Compliance and Quality Manager moving forward, and it is hoped compliance can be secured from the GP's supporting the home.

Proposed Timescale: 30/12/2016

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:

There was no choice offered to residents at mealtimes on the first and second floors.

The menu was not accessible to residents on the first and second floors

8. Action Required:

Under Regulation 18(1)(b) you are required to: Offer choice to each resident at mealtimes.

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

Pictorial menus have been completed and are now ready for use on all floors to ensure residents especially those with communication difficulties can make their choices known. All residents continue to be offered visual choice through visual plating of meals at mealtimes on all floors.

Proposed Timescale: 30/12/2016

Theme:

Person-centred care and support

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

The system of communicating residents current dietary requirements with the kitchen requires review.

9. Action Required:

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

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

Food plans and dietary requirements had been updated prior to the inspection and are now available to all kitchen staff. These reflect fully the dietary requirements of each resident and any/all recommendations made by healthcare professionals. The Home Manager meets with the Catering Manager regularly, typically on a daily basis to ensure communications regarding all residents is continually updated. Nursing Staff will provide the Catering Team with the resident's current dietary requirements weekly (on Mondays) or upon admission of a new resident to ensure all resident's needs are communicated to the catering team and updated regularly.

Proposed Timescale: completed July 30th, 2016

Proposed Timescale: 30/07/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

The number of staff nurses during the day was not adequate to meet the assessed needs of residents.

The size and layout of the premises not fully reviewed as part of any staffing review

10. 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:

As was discussed at feedback with the inspectors it is important to point out again that Blainroe Nursing Home has allocated the resources to fund the required number of nurses to meet our resident's needs.

With the worldwide shortage of nurses, it takes time to recruit replacement nurses, usually from abroad, as there are very few Irish Nurses available. Training these new nurses requires between 12 and 16 weeks off the floor before they can be rostered as staff nurses to care for our residents.

FirstCare had reviewed the staffing requirement in the nursing home prior to this inspection and had allocated an additional nurse from 2pm -8pm. We have recruited 4 fulltime nurses post inspection. Two of these have just completed adaptation and are currently awaiting their ABA pins.

In the interim, whilst staff nurses are being inducted, additional care staff are rostered daily to ensure the needs of the residents were met, ensuring adequate supervision takes place within the home.

Additionally we have recruited a second Clinical Nurse Manager since the last inspection. At this present time both Clinical Nurse Manager positions are filled and the Home Manager is supported by these two staff across 7 days.

Proposed Timescale: 30/01/2017