<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Blainroe Lodge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000016</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Coast Road, Blainroe, Wicklow.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>0404 60030</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:blainroe@firstcare.ie">blainroe@firstcare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Firstcare Ireland (Blainroe) Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila Doyle</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>70</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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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 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 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
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<tbody>
<tr>
<td>20 August 2018 10:30</td>
<td>20 August 2018 17:30</td>
</tr>
<tr>
<td>21 August 2018 09:00</td>
<td>21 August 2018 14:30</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents’ Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Substantially Compliant</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
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<td>Compliant</td>
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Summary of findings from this inspection

The person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the centre’s and inspector’s rating for each outcome.

Blainroe Lodge is a three-storey centre with a basement, which provides residential care for 71 people. Approximately 66% of residents have dementia. This centre does not have a specific dementia unit although many of the residents reside on the first floor.

Each resident was assessed prior to admission to ensure the service could meet their
needs and to determine the suitability of the placement. Following admission, residents had a comprehensive assessment undertaken. A number of issues were identified in relation to the development, review and implementation of care plans. Some improvements were also required to ensure that meals and mealtimes were an enjoyable experience for all residents. The inspector noted that residents were not consistently afforded the opportunity to outline their end of life wishes.

Some improvement was required to ensure consistent meaningful engagement by staff. The inspector saw many examples of good practices in relation to maintaining residents' privacy and dignity but improvements were also identified.

Measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Improvements were required to ensure that residents were sufficiently safeguarded when restraint was in use and that the use of restrictive practices was in line with national guidelines.

A staffing level review is required to ensure that adequate staff are available to meet the needs of the residents.

These are discussed further in the report and included in the Action Plan at the end of this 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 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:**
The inspector found that each resident’s wellbeing and welfare was maintained by appropriate evidence-based nursing, medical and allied health care. However, a number of issues were identified in relation to the development, review and implementation of care plans including end-of-life care plans. Some improvements were also required to ensure that meals and mealtimes were an enjoyable experience for all residents including residents with dementia.

On admission to the centre, each resident’s needs were comprehensively assessed. Risk assessments were completed for a number of areas such as falls and pressure area care. Each resident had a care plan completed. This mostly identified their needs and the care and support interventions that would be implemented by staff to meet their assessed needs.

Action required from the previous inspection relating to updating the care plans following recommendations by members of the multidisciplinary team had not been completed. In the sample of care plans reviewed, the inspector noted that while changes to care had been implemented, the care plans had not been amended to reflect this. In general, the inspector found that care plans were also not being updated to reflect the residents' changing condition. This was noticed in the care plans of residents with dementia relating to falls management, weight management and mobility care plans.

In addition, the inspector noted that, although care plan reviews were carried out on a three monthly basis, there was no documented evidence that residents or their family were consulted in this regard.

Residents had access to a varied, nutritious diet and a choice of menu was offered at mealtimes. The inspector was satisfied that residents with special dietary requirements were provided with the appropriate diet. However, improvements were required to ensure that mealtimes were enjoyable social events. It was unclear if sufficient staff
were available to assist residents as the inspector saw that some residents had their meal placed in front of them even though assistance was not available. This applied in particular to residents with higher dependencies especially residents with dementia.

The inspector also noted that plastic cutlery was used for the mid-morning snack and disposable plastic cups were used for drinks for some residents. Both of these impacted on the residents with dementia and their ability to manage independently. The inspector also noted that tables were not consistently laid, and meals, particularly teas, were not served in any particular manner. For example, the inspector saw that a resident had a sandwich but did not have anything to drink. Hot and cold drinks seemed to be served at the same time thereby increasing confusion for some residents with dementia. Condiments were not available on the tables.

The inspector also noted that teas were served at 4:15pm which is not a conventional mealtime. Some residents told the inspector that they found this a bit early. Insufficient evidence was available as to whether the timings were to suit the needs of the residents or the staff routines.

Staff provided end-of-life care for residents with the support of the resident's GP, and the palliative care team if required. The inspector found that residents were not consistently afforded the opportunity to outline their wishes and preferred priorities of care. Two of the four care plans reviewed of residents with dementia did not outline these preferred priorities of care. This information could then be used to plan the care to be provided.

Many of the hospice friendly hospital initiatives had been implemented such as the use of the spiral symbol. The person in charge discussed plans to get some specific handover bags for residents' possessions.

The inspector found that, at the time of inspection, residents were protected by safe medication management practices. Written evidence was available that three-monthly reviews were carried out. Support and advice were available for the supplying pharmacy. While some gaps were noted in the prescription template, the person in charge discussed plans afoot to bring in new templates for use.

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

Residents had access to GP services and out-of-hours medical cover was provided. A full range of other services was available on referral including physiotherapy and occupational therapy (OT) services. Chiropody, dental and optical services were also provided. The inspector reviewed residents’ records and found that some residents had been referred to these services and results of appointments were written up in the residents’ notes.

Judgment:
Non Compliant - Moderate
**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
Measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Improvements were required to ensure that residents were sufficiently safeguarded when restraint was in use and that the use of restrictive practices was in line with national guidelines.

The inspector reviewed the use of restraint and noted that risk assessments had been undertaken. Some additional equipment such as low beds had been purchased to reduce the need for bedrails. There was documented evidence that alternatives had been tried prior to the use of restraint. However, care plans did not consistently outline the care to be provided to the resident when restrictive practices were in use. In addition, there was no documented evidence that safety checks were being completed in line with national policy.

Staff had received training on identifying and responding to elder abuse. There was a policy in place to guide practice. Staff spoken with displayed sufficient knowledge of the different forms of elder abuse and all were clear on reporting procedures.

Procedures were in place to ensure that residents were provided with support that promoted a positive approach to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The inspector reviewed residents’ files and noted that a comprehensive assessment had been undertaken. Possible triggers had been identified and staff spoken with were very familiar with appropriate interventions to use.

During the inspection staff approached residents with responsive behaviours in a sensitive and appropriate manner and the residents responded positively to the techniques used by staff. The inspector saw that additional support and advice were available to staff from the psychiatric services.

This provider currently acts as a pension agent for some residents. These are managed centrally through the head office. The inspector saw written confirmation of recent changes to ensure compliance with national guidelines.

Pocket monies were managed for some residents. Detailed documentation including receipts was maintained. A monthly audit was carried out on balances. The inspector
checked a sample of balances and found them to be correct.

**Judgment:**
Non Compliant - Moderate

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**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:**

Improvement was required to ensure that all interactions resulted in a positive outcome for residents and that their privacy and dignity was consistently respected.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia. The observations took place in the day rooms and the dining rooms. Observations of the quality of interactions between residents and staff for selected periods of time indicated that 21% of interactions demonstrated positive connective care, 33% reflected task orientated care, 25% indicated neutral care, 4% protective and controlling care while 17% of interactions classed as institutional care.

Generally, staff were seen to give an explanation to residents before they offered support and assistance. However, the inspector noted one staff member putting a clothes protector on a resident without asking permission or even explaining what was happening. Another staff member was assisting a resident with a meal and the only conversation heard was 'come on'. Another staff member went into a day room set aside for residents with dementia and changed the television channel without making any contact with the seven residents sitting there.

These observations and results were discussed with the management who attended the feedback meeting and agreement was reached that this would be addressed as a matter of priority.

Otherwise the inspector saw many examples of good practices. Staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. Staff were observed knocking on bedroom and bathroom doors. Adequate screening was available in shared rooms. The screens in one twin room had been raised to allow for the use of the hoist. The person in charge said that they had identified that this screening was now too short and would be addressed.

The inspector observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff knew the residents well. The inspector noted good
humoured banter between the residents and staff.

Independent advocates were available and contact details were on display in the front hall. There were no restrictions to visiting in the centre and many residents were observed spending time with family or friends. During the day residents were observed to move around the centre freely.

Residents were facilitated to exercise their civil, political and religious rights. Residents confirmed that their rights were upheld. Residents' right to refuse treatment or care interventions were respected. Arrangements were in place for residents to vote in the recent election.

There was a residents’ committee in operation. The inspector viewed the minutes of some meetings and saw that suggestions made by residents had been taken on board.

'A key to me' was completed for each resident and this included details of residents' likes and dislikes, previous interests and hobbies. Some dementia appropriate activities were available and a programme of activities was on display. This included music, games and crafts. One to one activities such as hand massage, were carried out for residents who did not wish to engage in group activities.

**Judgment:**
Non Compliant - Moderate

<table>
<thead>
<tr>
<th><strong>Outcome 04: Complaints procedures</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td>Person-centred care and support</td>
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<tr>
<td><strong>Outstanding requirement(s) from previous inspection(s):</strong></td>
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<tr>
<td>No actions were required from the previous inspection.</td>
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**Findings:**
The inspector read the complaints log and noted that the number of complaints received was minimal. However, the policy needed to be amended to include details of the persons nominated for specific roles as required by the regulations. In addition the procedure on display required updating to reflect changes in personnel.

**Judgment:**
Substantially Compliant

<table>
<thead>
<tr>
<th><strong>Outcome 05: Suitable Staffing</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
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Page 9 of 18
### Workforce

<table>
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<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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**Findings:**
The inspector found that, at the time of inspection, there was insufficient evidence that there were appropriate staff numbers and skill mix to meet the assessed needs of residents for the size and layout of the centre. Some review was required, to ensure that adequate assistance was available to residents when required, which is discussed in more detail under Outcome 1.

It was noted that recruitment was ongoing in the centre to fill existing vacancies. Assurance was given by the person in charge that Garda Síochána (police) vetting was in place for all staff.

The inspector reviewed a sample of staff files and saw that all documents required by Schedule 2 were in place.

A staff training programme was in place and a record of training for all staff was available. All mandatory training was completed. The majority of staff had recently completed dementia specific training and additional training was planned.

Volunteers attended the centre and provided very valuable social activities for the residents which residents confirmed they really enjoyed. Garda vetting was in place. Some improvement was required to ensure that the roles and responsibilities were set out in writing as required by the regulations.

**Judgment:**
Substantially Compliant

### Outcome 06: Safe and Suitable Premises

**Theme:**
Effective care and support

<table>
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<tr>
<th>Outstanding requirement(s) from previous inspection(s):</th>
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<tbody>
<tr>
<td>No actions were required from the previous inspection.</td>
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</table>

**Findings:**
Blainroe Lodge is a three-storey building with a basement. Residential accommodation is across the four floors which are accessed by a lift and stairs.

In total, there are 34 single rooms with full en-suite facilities, 26 single rooms with toilet and wash-hand basin and three additional single rooms. There are four twin rooms with
full en-suite facilities. Many of the rooms have been personalised with family photos and memorabilia. Additional toilets and bathrooms were located around the building.

There were adequate communal areas and private areas for residents to receive visitors. The inspector noted that the reception area was popular for residents. Other areas include a kitchen, laundry, oratory, hairdressing salon, smoking room and activities room.

The premises was well maintained to a high standard, clean, comfortable and homely. Extensive work had been undertaken to make the centre dementia friendly. There were various sensory and tactile boards and walkways, and areas decorated with memorabilia suitable for the needs of residents. The inspector saw that the use of contrasting colours was also evident in the toilets and bathrooms.

Assistive equipment was provided where necessary, and was in good working order and regularly serviced.

There are several enclosed garden areas which are well maintained. Adequate parking is provided at the front and side of the building.

**Judgment:**
Compliant

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**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 Doyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Blainroe Lodge</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000016</td>
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<tr>
<td>Date of inspection:</td>
<td>20/08/2018 and 21/08/2018</td>
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<tr>
<td>Date of response:</td>
<td>17/09/2018</td>
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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 Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Care plans did not contain sufficient detail to guide practice.

Care plans were not consistently updated following changes in the resident's condition.

1. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
The Person in Charge (PIC) and Clinical Nurse Manager’s (CNM’s) have begun a further review of all care plans in light of the feedback from this inspection, in conjunction with the Nursing and Social Care teams, with a specific emphasis on end of life care planning.

Following feedback from the inspection the PIC and nursing team have commenced a process whereby all residents now have a named nurse, who will be responsible for engaging with residents and their families regarding care planning. This consultation will be reflected in the care plans and part of the monthly audit cycle.

Multi-Disciplinary Team (MDT) reviews will also be included in the plan to ensure the named nurse updates the care plans as required. Care plans will be completed for all new residents as per our policy. PIC will continue to audit care plans on a monthly basis and provide feedback to nurses and CNMs in relation to actions required.

The Training and Development Coordinator is currently sourcing further specific care planning training for all staff nurses. The PIC will provide information on staff training requirements to the Training and Development Coordinator to source appropriate courses.

The PIC will provide monthly feedback to the Group Director of Operations on these audits and any requirements arising.

Proposed Timescale: 14/12/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that residents or their families, where appropriate, were consulted regarding the review of the care plan.

2. Action Required:
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

Please state the actions you have taken or are planning to take:
Named nurses are now in place for all residents and a comprehensive plan in place to ensure all residents have their care plans reviewed and discussed with our resident themselves if appropriate, or their nominated Next of Kin (NOK) on at least a quarterly basis or sooner if required.
Over the next three months each of our residents will have had their care plans reviewed, updated, discussed, and signed off by either the resident or their NOK as appropriate.

Inclusion of resident and their next of kin in care planning will be monitored within the audit going forward.

**Proposed Timescale:** 14/12/2018

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Residents were not consistently afforded the opportunity to outline their wishes and preferred priorities of care which could inform the end-of-life care to be provided.

**3. Action Required:**
Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

**Please state the actions you have taken or are planning to take:**
Currently 56 residents already have initial end of life and/or NFR care plans in place. These will be further reviewed and evaluated in line with the named nurse programme to ensure all details are current and recorded for each resident. The PIC will purchase specific handover bags for resident possessions. Residents who do not already have an end of life care plan in place will be met, or a meeting with their NOK will be arranged, to discuss their wishes and commence a care plan with the information provided.

**Proposed Timescale:** 14/12/2018

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no obvious system behind the serving of meals.

Plastic cutlery and containers were in use.

**4. Action Required:**
Under Regulation 18(1)(c)(i) you are required to: Provide each resident with adequate quantities of food and drink which are properly and safely prepared, cooked and served.

**Please state the actions you have taken or are planning to take:**
Timescale: COMPLETE
The unfortunate error of plastic cutlery in use on the day of inspection was rectified immediately. The kitchen manager was notified immediately to cease such use and to ensure removal of all plastic cutlery and containers. Plastic cutlery is no longer in use, and was a one off event. All staff are aware that disposable cups are for staff use only and stored in such a way that residents cannot access in error. All homesteads have been restocked with all essentials required to ensure a smooth service and efficient availability for staff and residents. New ramekin containers have been sourced for the serving of fruit pots.

Mealtimes have been reviewed in consultation with Kitchen Manager, and a new system of serving has been implemented, resulting in the approach to mealtimes being more calm and relaxed, with each dining area being served individually and systematically with appropriate assistance from staff.

Mealtime audits and food survey audits will continue monthly to ensure residents and or their families have the opportunity to give feedback on the revised system.

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<th>Safe care and support</th>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Evening teas were being served at 4:15pm.

5. **Action Required:**
Under Regulation 18(2) you are required to: Provide meals, refreshments and snacks at all reasonable times.

**Please state the actions you have taken or are planning to take:**
Revision of the PIC and CNM rosters has commenced to ensure senior management is available to monitor the teatime daily. All staff aware that tea is not to be served at 4.15pm. Tea time has been reviewed and changes made to the serving of same have been implemented.

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
It was unclear if sufficient staff were available to assist residents as several residents were left with their meals untouched.
6. **Action Required:**
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

**Please state the actions you have taken or are planning to take:**
Timescale: COMPLETE
Teatime is now divided into two separate serving times with soup and sandwiches being served first and the main evening tea being served at a later time. Each lounge is being served from their own homestead and staff allocations have also been reviewed and amended to ensure that staff are available to provide assistance.

**Proposed Timescale:**

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Care plans did not consistently outline the care to be provided to the resident when restrictive practices were in use.

There was no documented evidence that safety checks were being completed.

7. **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:**
In line with Outcome 1, all residents’ care plans are currently under review. Any resident that requires bedrails and/or specialised chairs has an assessment in place. OT assessments have also been completed on those residents that require a specialised chair and lap belt. Currently we are researching an assessment tool for the use of lap belts, which are only being used on those residents that have been assessed by the OT and require same for safety reasons.

Restraint release and safety checks will be documented on Epic as part of resident’s daily care. Training for all staff has commenced in relation to the documentation of same daily. The current Policies and Standard Operating Procedures in relation to restrictive practices is being reviewed and will be updated accordingly.

**Proposed Timescale:** 19/10/2018

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**Outcome 03: Residents’ Rights, Dignity and Consultation**
Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvement was required to ensure that all interactions resulted in a positive outcome for residents and that their privacy and dignity was consistently respected.

8. Action Required:
Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

Please state the actions you have taken or are planning to take:
On receiving specific examples of practice and interactions that requires improvement from the inspector, the senior staff followed up directly with the team members. Ongoing training will be provided to all staff in relation to their interactions with residents. The PIC is liaising with the Hospice Foundation who provide specific training in communication skills for staff who are caring for residents living with a dementia.

Further MAPA training, and training in dealing with behaviours that can challenge, has already been booked with one session already completed. Interactions will be monitored daily by PIC and CNM’s to ensure all staff continue to engage with residents in a respectful and dignified manner and continue to promote a positive environment for our residents.

Proposed Timescale: 14/12/2018

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Staffing levels required review to ensure that adequate staff were available to residents.

9. 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:
Timescale: COMPLETE
Due to a combination of sickness and a number of newly appointed staff unable to be included on the roster until their Garda vetting was fully processed, we were understaffed on the first day of the inspection, with no availability of agency to replace these staff. These new fulltime Healthcare Assistants that were in the process of
completing Garda Vetting and general compliance, are either now working on the floor, or will be shortly on the floor, giving the home an appropriate staff complement and skill mix.

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<td><strong>Theme:</strong></td>
</tr>
<tr>
<td>Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The roles and responsibilities of volunteers were not set out in writing as required by the regulations.

**10. Action Required:**
Under Regulation 30(a) you are required to: Set out in writing the roles and responsibilities of people involved on a voluntary basis with the designated centre.

**Please state the actions you have taken or are planning to take:**
Timescale: COMPLETE
Each volunteer now has their roles and responsibilities clearly defined, explained and signed off by the volunteers themselves, and attached to their personnel file. These roles have been explained to all staff and copies of their roles and responsibilities are available for inspection.

<table>
<thead>
<tr>
<th>Proposed Timescale:</th>
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