Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Kylemore House Nursing Home
Centre ID:	OSV-0000055
Centre address:	Sidmonton Road, Bray, Wicklow.
Telephone number:	01 286 3255
Email address:	info@kylemorehouse.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Kylemore Nursing Home Limited
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Mary O'Donnell
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	33
Number of vacancies on the date of inspection:	5

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 1 day(s).

The inspection took place over the following dates and times

From:	To:
12 July 2018 10:30	12 July 2018 18:30
12 July 2018 10:30	12 July 2018 18:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Not applicable	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Not applicable	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Not applicable	Non Compliant - Moderate
Outcome 04: Complaints procedures	Not applicable	Substantially Compliant
Outcome 05: Suitable Staffing	Not applicable	Non Compliant - Major
Outcome 06: Safe and Suitable Premises	Not applicable	Non Compliant - Moderate
Outcome 08: Governance and Management	Not applicable	Non Compliant - Moderate
Outcome 09: Statement of Purpose	Not applicable	Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. The inspection also considered notifications and other relevant information.

Notwithstanding improvements made by the provider to the environment and service to date, significant improvement was found to be necessary in the governance and management systems to ensure an effective and appropriate standard of clinical care was delivered to residents, in accordance with the statement of purpose.

Staffing levels and skill-mix were not appropriate to meet the needs of residents. Inspectors' findings did not provide sufficient assurances that there was adequate staff available to meet residents' care, safety and supervision needs. Insufficient staffing and inadequate staff supervision negatively impacted on the care, safety and welfare of residents in the centre. This outcome merited a judgment of major non compliance. The provider revised staffing arrangements immediately and rostered additional staff to ensure the quality and safety of care for residents was assured.

There were policies and procedures available to inform safeguarding of residents from abuse. A restraint free environment was promoted and care practices and interactions between staff and residents were respectful and courteous. From the files examined it was evident that the assessment and management of behaviours and psychological symptoms of dementia was not in line with the centre's policy.

Inspectors met with residents, their relatives and staff members. Residents who spoke with inspectors said they felt safe and expressed their satisfaction and contentment with living in the centre. Good efforts were made to support residents with dementia to maintain links with their community but improvements were necessary to ensure each resident was facilitated to enjoy meaningful and fulfilling recreational activities that met their interests and capabilities.

The action plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centre's for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland 2016.

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 findings of this inspection are that the registered provider failed to ensure that some residents were provided with the required level of nursing care and supervision in order to ensure that they were safe and well cared for. The absence of sufficient detail in some residents' care plans did not ensure their care needs were comprehensively described or met to a sufficient standard.
For example;
• information was absent regarding frequency of dressings for wound care
• catheter care procedures were not described for a resident at risk of urinary tract infection and practices observed by inspectors increased the risk of an infection developing
• recommendations by the speech and language therapist for residents with identified swallowing difficulties were not always accurately recorded in care plans and were not consistently implemented or known by all staff
• care procedures to mitigate identified risk to residents of developing pressure related skin breakdown were not sufficiently described or implemented. A resident with a sacral wound was not provided with a cushion, records of assistance with position changes were not maintained and there was an inadequate system in place to ensure that pressure relieving mattresses were maintained at an appropriate level. Although there was a low incidence of pressure ulcers occurring, these findings did not promote skin integrity
• some residents' end-of-life and activity needs were not assessed and informed by a care plan. Consequently not all residents with dementia had opportunities while they were able to express their wishes and choices regarding their end-of-life care including where they wished to receive care. The person in charge said that some residents would find a discussion about their wishes for end-of-life care distressing.

These findings evidenced that the absence of a high standard of effective and appropriate nursing care and supervision was negatively impacting on residents' health, wellbeing and quality of life.

The inspectors also found evidence of good practices in the designated centre including;
• where possible, residents with dementia or their relatives on their behalf were consulted regarding their care plan development and reviews. Relatives who spoke with the inspectors confirmed that the staff team maintained good communication with them.
• There were a low number of incidents of residents falling and sustaining an injury with residents assessed for risk of falls on admission and regularly thereafter.
• There were arrangements in place to review accidents and incidents within the centre.
• Residents were encouraged to maintain their independence, and their mobility needs were supported by a variety of assistive equipment and assistance by staff. Use of low level beds, foam floor mats and sensor alarm equipment was used to mitigate risk of some residents falling. Residents needing hoist equipment to assist their transfer were provided with individual hoist slings.
• The provider had ensured that improvements were made to medication management practices since the last inspection. Inspectors found that residents were now protected by safe medicines management practices
• The person in charge or her deputy visited prospective residents in hospital or their home in the community prior to admission to ensure the service could meet their needs. Some residents with dementia also transitioned from respite care or from the adjacent day care service run by the provider to continuing care in the centre. Prospective residents and their families were welcomed to view the facilities and discuss the services provided before making a decision to live in the centre. These arrangements gave residents and their families information about the centre and also ensured that the service could adequately meet their needs.
• The provider ensured that the health needs of residents with dementia were met with timely access to medical and allied health professionals as necessary. An on-call emergency GP service was available out-of-hours and residents with dementia were supported as necessary by the community psychiatric services.

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:
This inspection found that the systems in place to ensure the safety of residents required improvement.

Appropriate measures were in place to safeguard and protect residents with dementia from abuse. For example, residents said that staff were always respectful and courteous towards them and there were systems in place for the management of residents'

finances on their behalf. Residents' money was held securely and was available to residents as they wished. The provider was a pension agent for collection of six residents' social welfare payments on their behalf. Residents' social welfare pensions were paid into individual named accounts and arrangements and transactions were transparent and in line with the legislation.

The areas that required review were as follows:

Behaviour support care plans lacked detail of residents' specific behaviours. Specific behaviours were not documented in a manner that facilitated analysis and review. Behaviours were generally documented in the daily narrative notes and not in a behavioural chart where incidents of behaviour could be analysed and used to inform a plan of care.

Fourteen residents used bed rails and alternatives tried before using full-length bedrails were not consistently recorded. The person in charge told inspectors that staff removed bedrails at regular intervals to minimize the periods residents were restricted by this equipment, and completed a safety check each time they were put back in place. However, there was insufficient information recorded to provide assurances that these procedures were consistently completed by staff. The absence of consistent safety assessments to inform safety of bedrail use for individual residents did not mitigate their risk of injury while this equipment was in use.

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Inspectors found that residents with dementia were not given sufficient opportunities to participate in activities that were meaningful and purposeful to them and reflected their interests and capabilities. An activity coordinator was employed to facilitate activities from 09:00hrs to 14:00hrs five days each week. An activity schedule was displayed. The activity coordinator was on leave since 2 July and no organised activities were facilitated for residents on the day of inspection. There was an over-reliance on the television for residents in the communal rooms on both floors. While the person in charge told inspectors that a plan was in place to complete 'key to me' information for each resident, this had not commenced and the activity needs of residents with dementia were not assessed. Consequently, many residents with dementia spent their day in the sitting rooms and were not supported to engage in any recreational activities that

interested them or suited their capabilities. These findings did not provide sufficient assurances that residents' lives were positively enhanced by the activity programme provided in the centre to meet their interests and capabilities.

The provider and person in charge ensured that residents with dementia were supported to participate in the running of the centre through regular residents' meeting forums. The provider and person in charge welcomed residents' feedback and had made improvements to the environment to enhance their quality of life in the centre. There was a lot of emphasis on maintaining residents' links with the community and supporting them to continue to attend various day centres in the locality after they moved into the centre. Some residents were encouraged to continue to enjoy going out to the local town and the seafront with their family and friends. The provider also employed people to accompany residents with going for walks in around the local area.

Inspectors' found that residents with dementia were mostly supported to exercise personal choices about how they wished to spend their day. For example, some residents liked to get up late in the morning and this was facilitated. Staff were also observed offering choices to residents about menu options and where they wished eat their meals or sit during the day in ways that suited their communication needs. However, independent choice to freely access the external environment was restricted for residents with memory impairment, due to key code locks placed on doors to the outdoor enclosed balcony and garden area.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record these interactions at five minute intervals in the dining-room and sitting room on the ground floor and a dining/sitting room on the first floor. Scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the quality of the interactions with the majority of residents. Inspectors' observations concluded that while there were some observations of positive connective care provided to residents by staff, many of the observations reflected neutral and task orientated care. Residents on the ground floor who required assistance had one to one assistance and the meals were appropriately paced. The dining experience for these residents could be enhanced if a dining table was provided and attention paid to the background music played during mealtimes.

Staff ensured that residents' privacy and dignity needs were respected by knocking on bedroom and bathroom doors before entering rooms, and by ensuring doors and bed screens were closed while they assisted residents with their personal care.

Residents' communication care needs were assessed and documented in their care plans. Staff were aware of each resident's communication needs, particularly the needs of residents with dementia. Text was used on the television for residents who had hearing difficulties. The availability of simple devices such as a white board or paper and pens would further benefit residents who had hearing impairment. Large font signage was in place to support residents with vision difficulties.

There was an open visiting policy in place with protected mealtimes for residents. Inspectors observed friends and relatives visiting residents throughout the day of

inspection. There were areas including a quiet room in the centre where residents could meet their visitors in private if they wished.

Newspapers were made available for residents so they could keep up to date on local news from their community. Wireless internet was available in the centre in addition to a telephone which residents could use.

Residents were facilitated to exercise their civil, political and religious rights. Residents were supported to vote in the centre and residents of the various faiths could practice their religions.

Judgment:
Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
Residents confirmed that any areas of concern were dealt with. The complaints policy was available in the reception area and the appeals process was clearly stated. The record of complaints held details of six complaints which were investigated in 2017 and there were no complaints recorded for 2018. The person in charge identified one compliant which she failed to record.

Advocacy services were available to assist residents as necessary.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Inspectors found that the number of nurses and health care assistants employed was significantly less than the staffing levels set out in the centre's Statement of Purpose. Staffing levels and the deployment and supervision of staff did not ensure the quality and safety of care for residents and were

During the inspection the provider confirmed that staffing levels had been reduced in line with the reduction in occupancy levels in the centre. In addition the person in charge told the inspectors that four staff had resigned in recent months. The centre had commenced a recruitment process to replace these staff and two new care assistants were due to start employment in the coming week.

Inspectors reviewed the rosters and found that the processes in place to ensure that there were sufficient staff on duty in the centre, were not adequate. Rosters for the preceding four weeks indicated that the person in charge worked from 08:30 hours to 17:30 hours on Monday to Friday. Residents were accommodated on two floor and there were nine days when there was only one nurse rostered to work when the person in charge was on duty. There were 13 days when there was one nurse on duty between 14.00 hrs and 08:00 hrs the following morning. Staffing at the weekends was inconsistent. Over a four week period, there were three weekend days when there was only one nurse on duty for a 24 hour period. This level of nursing staff was inadequate to undertake nursing assessments, deliver nursing care, administer medications and supervise the care delivered by care assistants.

Suitable relief or agency staff were not consistently employed to replace staff who were on unplanned and planned leave.
Inspectors met with a number of staff who reported that the staffing levels were inadequate to meet the needs of residents across two floors. They reported that they were rushing to complete their work and were often unable to respond to call bells or provide assistance to residents in a timely manner. Inadequate staffing and poor supervision of care delivery impacted on outcomes for residents in relation to meeting their healthcare, nursing and social needs as detailed in outcomes one and three. Inspectors also found that staffing levels had not been revised following a serious incident that had occurred in the centre.

In addition inspectors found that the quality and safety of care and services delivered were not adequately monitored. For example residents were not consistently supervised in the ground floor sitting room. Although low in frequency, the three falls that resulted in an injury to residents in 2018, notified to the Office of Chief Inspector occurred between 20:00 and 08:00 hours and were not witnessed by staff.

All staff had completed mandatory training and the induction programme for new staff covered mandatory training topics such as fire safety and safeguarding. Dementia training including training on behaviours that challenge was delivered in 2016. The majority of staff knew residents well but some staff on duty were not sufficiently knowledgeable regarding residents' individual needs and the triggers for challenging behaviours. Inspectors found that staff would benefit from further training and updates in challenging behaviours, care planning and restraints.

Although the provider had made efforts to recruit replacement staff the current staffing levels did not take into account the dependency of the residents and the design and layout of the centre. As a result inspectors found that the provider had not ensured that staffing levels were appropriate to ensure that the care and safety needs of residents were consistently met.
The provider revised staffing arrangements immediately and rostered additional staff to ensure the quality and safety of care for residents was assured.

The person in charge confirmed that all staff had An Garda Siochana vetting in place. The contract with the agency who provided relief staff confirmed that the agency staff on duty had been appropriately vetted.

Judgment:
Non Compliant - Major

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The centre was originally a period house. The provider had extended and refurbished the centre and made the environment comfortable and homely for residents, including residents with dementia.

The following areas were identified as needing improvement to ensure the centre met the individual and collective needs of residents, especially residents with dementia.
• Sluicing facilities were not adequate. There was one sluice on the first floor to meet the needs of all residents in the centre. This arrangement did not support the safe disposal of potentially infectious waste products from residents on the ground floor. Disinfection procedures described by staff did not provide assurances that bed pans, urinals and commode basins were effectively decontaminated to mitigate the risk to residents of cross infection.
• Some bathrooms and toilets did not have suitable grab rails fitted to promote the independence of residents with dementia and mitigate their risk of falling
• Storage for residents' assistive equipment was inadequate and hoists and a commode were stored in residents' bedrooms when not in use.

There was also improvement opportunities for staff to extend support with personalisation of bedrooms for residents with dementia who do not have family supports. The use of pictures and photographs on bedroom doors could also be developed further to support residents with dementia to locate their rooms. Consideration should also be given to control of stimuli for residents with dementia, such

as noise and the appropriateness of the music being played on the radio in the day rooms. The communal room on the ground floor, where the more dependent residents with dementia spent their day, lacked natural light. Limited natural light is not in line with best practice standards for residents with dementia due to their potential for altered perceptions of their environment.

Inspectors also observed areas of good practice regarding the designated centre that positively impacted on the wellbeing, safety and quality of life of residents in the centre. For example:
• residents had access to indoor and outdoor areas and to secure external areas with colourful floral containers and suitable garden furniture. External grounds were well maintained
• sitting and dining rooms were spacious enough and were decorated in a homely and warm fashion. There were other communal areas on the ground floor for residents' use or to meet with their visitors in private
• signage throughout the centre was of a superior quality with pictures and text to support residents with dementia with way finding
• chair-lifts were available to assist people to navigate between floors. Inspectors were satisfied that only independently mobile residents were accommodated in bedrooms in the Victoria wing, as set out in the centre's statement of purpose
• corridors and door entrances used by residents were sufficiently wide to facilitate movement and aids used and required by residents. Bedrooms were adequate to accommodate personal equipment and devices required by existing residents
• handrails were provided in circulating areas.
• Bedroom accommodation was provided with mostly single room accommodation. The size and layout of bedrooms met the needs of the residents
• privacy screening was designed in shared rooms, to enable the screen to close fully around the resident's bed.
• Families were supported to personalise residents' bedrooms with photographs and personal items,
• the centre was warm, well maintained and suitably decorated
• the provider ensured furniture and equipment seen in use by residents was in good working condition. Mobility aids that included remote control beds and hoists were available to promote safe moving and handling practices.

Judgment:
Non Compliant - Moderate

Outcome 08: Governance and Management

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:
The governance and management of the centre required improvement to ensure that the service provided was safe, appropriate, consistent and effectively monitored and as described in the centre's statement of purpose.

While monitoring systems were in place, with KPI reviews and auditing procedures completed by the person in charge, this process was not effective, in that it was not identifying deficits needing improvement regarding the quality and safety of residents' clinical care and their quality of life in the centre.

The staffing resource provided was insufficient to meet the care, supervision, safety and quality of life needs of residents with dementia. Staff supervision was not adequate. For example, inspectors found that some staff were not knowledgeable regarding the individual needs of residents and their safety needs were compromised as a result. Findings of insufficient staff supervision, direction and guidance were identified as needing improvement on the inspection in January 2017.

Judgment:
Non Compliant - Moderate

Outcome 09: Statement of Purpose

Theme:
Governance, Leadership and Management

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

Findings:
The provider had failed to include the following information as required by regulation 3 in the centre's statement of purpose document;
- The information as set out in the Certificate of Registration was not stated
- The total staffing complement, in whole time equivalents. The staffing arrangements as stated in the statement of purpose were not in place. The laundry service was outsourced and laundry staff as referenced in the statement of purpose were no longer employed in the centre.
- A description of the rooms in the designated centre including their size and primary function. Details about bedrooms and ensuite accommodation was not described on an individual bedroom basis.
- The organizational structure of the designated centre. The provider was not correctly identified in the organisational structure organogram and the provider representative was not specified
- Arrangements for the management of the designated centre where the person in charge is absent from the centre. Deputising arrangements for the person in charge were not stated.

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:

Catherine Rose Connolly Gargan
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 report[1]

Centre name:	Kylemore House Nursing Home
Centre ID:	OSV-0000055
Date of inspection:	12/07/2018
Date of response:	28/08/2018

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents' end-of-life and activity needs were not assessed.

1. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

[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:
• In relation to end of life needs the person in charge will re-audit all end of life care plans and ensure that all residents have their end of life care wishes and needs documented.

• In circumstances where a resident's express wish is not to have discussions about end of life and the resident's family had previously instructed the person in charge not to discuss this with the resident the person in charge will make every possible effort to ascertain end of life wishes and needs for all such residents by consultation with the families and or their representatives.

• This information will be included in their end of life care plan and will ensure that they receive end of life care in a way that respects their needs and wishes.

• The care plan audit outlined in Action 3 will ensure that all resident's activity needs have been assessed and documented and those needs will be met by the implementation of the programme as set out in Action 7.

Proposed Timescale: 30/09/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The recommendations made by the speech and language therapist for residents with confirmed swallowing difficulties regarding their food consistencies and supervision needs were not always implemented or known by staff.

2. Action Required:
Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

Please state the actions you have taken or are planning to take:
At present the following measures are in place:
a. A registered nurse is present at all main meal times to ensure residents with swallowing difficulty are provided with diet and fluids in accordance with their needs.
b. The person in charge met with all staff to further emphasise the necessity to be aware of and to implement recommendations for residents who require modified diet and/or fluids.
c. Information relating to resident's diet/fluid modifications are available to all staff in a variety of locations and format. These include:
1. Kitchen staff have a list of all resident's dietary needs including consistencies. This list is reviewed by registered nurses on a daily basis and updated in accordance with individual residents' dietary needs
2. Dysphagia mealtime plans are recorded on each resident's electronic healthcare record. These are available to care staff on the touch screen component of the electronic healthcare record.

3. Printed copies of resident's mealtime needs, including dysphagia mealtime plans are kept in a folder in a locked cupboard in each dining area. This folder also contains a summary sheet for each resident and also states dietary/consistency requirements. Prominent notices have been placed on these cabinets for ease of access and identification.
d. The registered nurse supervising mealtimes ensures that staff check this information at each meal.

These systems will be further supported by the following:
e. Individual resident's needs will be documented on a white board which will be placed in the staff handover area and will be concealed when handover has finished
f. The person in charge will implement Safety Pause Tool Kit at staff handovers, the key of which will highlight residents' safety issues including those residents with confirmed swallowing difficulties.
g. Nurses and care staff will be given pocket sized documented information on each resident's needs, including dietary needs and will be instructed that these documents must be returned to the staff nurse at the end of each shift for confidential shredding.
h. The person in charge will introduce an internal test system to ascertain staffs' knowledge on residents' risks including dietary risks.
i. We have spoken to the developers of the electronic healthcare record and requested that a prominent alert for residents with dysphagia will be available on each resident's healthcare record including the "routine daily care" record used by care assistants.
j. Modified diet and fluid training has been arranged for all clinical and non-clinical staff.

Proposed Timescale: 30/09/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some residents' care plans were not sufficiently detailed to inform the care they needed from staff to meet their needs.

3. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
• A sample care plan booklet is currently being updated to ensure it contains comprehensive information to assist staff nurses in the development of residents' care plans.

• The person in charge will allocate an equal number of care plans to individual staff nurses who will have responsibility for ensuring that their designated resident's care plans are sufficiently detailed to inform the care they require from staff to meet their needs.

• Staff nurses have again been informed that it is their responsibility to ensure that resident's assessments and care plans are updated if there is a change to a resident's condition during their time on duty.

• Each staff nurse will be instructed to audit their designated care plans using the audit tool available on the electronic audit programme.

• The person in charge will ensure that individual staff nurses are given protected time to review, update and audit care plans.

Proposed Timescale: 30/09/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A high standard of evidence based nursing care was not provided for residents with assessed risk of developing pressure ulcers, with urinary catheters, responsive behaviours, supervision while eating and transcription of residents' medicines.

4. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
• The care plan audit referred to in Action 3 will ensure that all care plans include detailed information is included to ensure that resident's care needs are comprehensively described.

• Documentation given to staff after each handover, referred to in Action 2, will include specific care needs for residents at risk of developing pressure ulcers such as recording of position changes, pressure relief mattress settings and provision of pressure relief cushions for residents when sitting out of bed.

• Catheter care procedures will also be included in this documentation.

• Care plans for residents with responsive behaviours will describe in detail possible triggers of such behaviours and will include information on how to deal with such situations.

• Please see Action 2 for supervision of residents while eating.

• Please see Action 5 for transcription of medicines.

Proposed Timescale: 30/09/2018

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Some medicines transcribed by nursing staff were not signed by a medical practitioner.

5. 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:
All medications transcribed by nursing staff have now been signed by a medical practitioner and the person in charge and registered nurses will ensure that this is always the practice.

Proposed Timescale: 20/07/2018

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Formal systems to quantify and analyse behaviours and the effectiveness of the interventions used were not in place. Behaviour support care plans lacked detail of residents' specific behaviours. Specific behaviours were not documented in a manner that facilitated analysis and review.

6. Action Required:
Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

Please state the actions you have taken or are planning to take:
☐Please see Action 4 for behaviour support care plans.
☐Staff nurses have been instructed to document incidents of responsive behaviours in detail document format on the electronic recording system. This document has a series of questions which gives a comprehensive description of each such event.
These measures will facilitate analysis and review by the clinical governance team and learning outcomes will be implemented.

Proposed Timescale: 30/09/2018

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:
Residents' activity needs were not assessed. Residents were not provided with sufficient opportunities to engage in activities to meet their interests and capabilities.

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

Please state the actions you have taken or are planning to take:
• The existing full range activity programme will be kept under active review by the Person In-Charge and manager of Social Programmes to ensure that the activities offered meet the social, occupational and recreational needs of the residents.
• " A key to me" is documented on hard copy and is in the process of being transferred to the electronic system for all our residents . Following this input of information an audit will be carried out to ascertain that the activities offered adequately meet the social, occupational and recreational needs of the residents. Any deficits will be discussed with all staff by the PIC.
• Funding has always been in place and continues to be in place to provide replacement staff when activity staff are on planned leave.
• Three care staff completed training in a gentle exercise programme called Fit for Life last year, and four staff including the activity provider have completed Sonas training.
• The person in charge will audit documentation of activities and any deficits will be discussed with all staff.

Proposed Timescale: 30/09/2018

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Some residents could not access outdoor areas as they wished due to use of key-code locks on doors to these areas.

8. Action Required:
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

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

• The key code lock will be deactivated on the ground floor rear door which accesses the outdoor area so that it is freely accessible to all residents. However it will be reviewed on an on –going basis
• The key code lock which accesses the first floor area will remain in place so that a resident is not placed at risk of injury by accessing the stairway located on the balcony area. If a resident wishes to access this area they will be supervised by a staff member or escorted to the ground floor is they wish to do so.
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Proposed Timescale: 28/08/2018

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Complaints management in the centre required review to ensure that all complaints are logged in line with the policy

9. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
• The provider representative has reviewed the complaints management and will continue to ensure that all complaints are logged in line with the complaints policy.
• The provider representative and PIC will ensure that all complaints or negative comments are logged in line with the complaints policy. They will be reviewed in our weekly meetings.

Proposed Timescale: 28/08/2018

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Staffing levels and the deployment of staff was not appropriate to ensure that the safety and care needs of residents were consistently met and this was resulting in negative outcomes for residents.

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:
1) A review of staff rosters and skill mix was undertaken by the provider representative and person in charge using an evidenced based assessment tool together with the person in charge's clinical and management experience. This will continuously be monitored using the methodology described above and will ensure that the number and skill mix of staff is appropriate to the number, dependency levels and assessed care needs of the residents, including changes in resident's dependency levels, new admissions and residents returning from hospital. This will ensure that safety and quality of care is provided for residents Following a meeting with HIQA on the 21st August a further review was undertaken and the suggestions made to the provider at that meeting have been incorporated into the action to be taken. The skill mix will be reviewed in our weekly meeting or more frequently if the need arises.
2) The current Staff Nurse numbers which was in place on the day of the inspection, facilitate two Staff Nurses on duty from 08.00 – 20.00 hrs.
3) A 20.00 – 22.00hrs rota will be introduced for the Nursing Staff from the 8th September. This rota will be achieved when one of the new Staff Nurses had completed her induction programme on the 8th September.
4) This new ratio ensures easy deployment of staffing within our two story building.
5) Please see Action 2 for ensuring staff are familiar with individual residents' needs.

Proposed Timescale: 30/09/2018

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Behaviours that challenge were not managed in line with the policy and staff would benefit from refresher training. Staff also had training needs in care planning. Some staff on duty were not sufficiently knowledgeable regarding residents individual needs.

11. Action Required:
Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.

Please state the actions you have taken or are planning to take:
• Our policy that guides management of responsive behaviours has been reviewed and is now specific to our centre.
• Training for staff in management of responsive behaviours has been arranged and all staff will be facilitated to attend.
• Care plan training for Staff Nurses in progress by person in charge.
• Please see Action 2 for knowledge on residents' individual care needs.
• Person in charge has ensured that any agency staff member works alongside a staff member who has knowledge of the residents' individual needs.
• Person in charge has also ensured that new or temporary staff members are informed

of how to access written documentation on residents' individual care needs

Proposed Timescale: 31/10/2018

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not appropriately supervised. Some staff were not sufficiently familiar with residents and their individual needs.

12. Action Required:
Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
a. The level of staffing rostered in the document submitted on the 13th July together with the actions in 10 above will ensure that staff are appropriately supervised.
b. Staff familiarity with residents needs is dealt with under Action 2

Proposed Timescale: 30/09/2018

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Sluicing facilities were not adequate. There was one sluice on the first floor to meet the needs of all residents in the centre. This arrangement did not support the safe disposal of potentially infectious waste products from residents on the ground floor. Disinfection procedures described by staff did not provide assurances that bed pans, urinals and commode basins were effectively decontaminated to mitigate the risk to residents of cross infection.

Some bathrooms and toilets did not have suitable grab rails fitted to promote the independence of residents with dementia and mitigate their risk of falling

Storage for residents' assistive equipment was inadequate and hoists and a commode were stored in residents' bedrooms when not in use.

13. 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:
• Hoists are stored in residents' bedrooms when the resident is not in their room so that they are readily accessible in case of emergency. They are stored in an alternative area when the resident is in their bedroom.
• Two residents choose to have commodes in their bedrooms. 1 of these 2 residents does not choose to use the communal areas and requests to have the commode in his room so he can access it independently.

Proposed Timescale: 28/08/2018

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There was insufficient staffing resources provided to ensure residents' clinical care, supervision, quality of life and safety needs were met.

14. Action Required:
Under Regulation 23(a) you are required to: Ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.

Please state the actions you have taken or are planning to take:
• A review of staff rosters and skill mix has been undertaken by the provider representative and person in charge using an evidenced based assessment tool together with the person in charge's clinical and management experience.
• Staffing has been reviewed and will continuously be monitored using the methodology described above and will ensure that the number and skill mix of staff is appropriate to the number, dependency levels and assessed care needs of the residents, including changes in resident's dependency levels, new admissions and residents returning from hospital. This will ensure that safety and quality of care is provided for residents.
• Two additional nurses had been recruited and their contracts are now signed and further nurses will be recruited as necessary to ensure that our nursing staff complement is in line with our statement of purpose.
• As documented in item 12 a further two staff nurses have been recruited. The number of registered nurses will ensure there are two on each day shift as well as the person in charge on weekdays.
• The person in charge will ensure the induction programme is fully completed for all new registered nurses and will work alongside them to ensure they are fully aware of the responsibilities of their roles.
• Annual leave and where possible unplanned absences will be covered by our bank of registered nurses who are all very familiar with individual residents' needs.

Proposed Timescale: 28/08/2018

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The monitoring system in place did not comprehensively inform the quality and safety of clinical care.

15. 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:
a. The person in charge will ensure that all Staff nurses have a performance appraisal completed at least annually and will provide training for any areas identified as being necessary.
b. The person in charge will appoint link nurses with responsibility in key risk areas of clinical care to include nutrition, infection control, dementia, falls, promotion of skin integrity and restraint. Appropriate training and support will be provided as necessary
c. In addition to the ad-hoc daily meetings a weekly recorded clinical governance meeting will take place between the Provider representative, the Person in Charge, Nursing staff and Manager. This will ensure stronger organisational and clinical leadership.
d. Within these meetings we will ratify, oversee and monitor the effectiveness of policies, systems and procedures that are in place. Change will be made where necessary in an effective manner to improve areas such as dietary needs or any other areas that are of concern and recorded on the Leadership Governance e and Management template.
e. Update the 'Statement of Purpose' to reflect changes resulting from these meetings
f. The provider representative will seek assurance from the person in charge that these priorities are being met through regular feedback, outcomes and incident analysis. Weekly discussions in these clinical governance meetings and analysis of incidents and findings of audits will prioritise and direct our actions.
g. The person in charge will be facilitated at attend a refresher course in clinical audit.
h. The person in charge will review the current audit programme to ensure that auditing systems will identify deficits that require improvement.
i. Results of all audits will be displayed in an area accessible to staff only and will be discussed at staff meetings.

Proposed Timescale: 17/10/2018

Outcome 09: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider had failed to include all the information required by regulation 3 in the centre's statement of purpose

16. Action Required:
Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Please state the actions you have taken or are planning to take:
• The statement of purpose has been reviewed and updated to contain all necessary information as required by schedule 1 of the regulations.

Proposed Timescale: 28/08/2018