<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Shannagh Bay Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000095</td>
</tr>
<tr>
<td>Centre address:</td>
<td>2-3 Fitzwilliam Terrace,</td>
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<tr>
<td></td>
<td>Strand Road,</td>
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<tr>
<td></td>
<td>Bray, Wicklow.</td>
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<tr>
<td>Telephone number:</td>
<td>01 286 2329</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:info@shannaghbay.ie">info@shannaghbay.ie</a></td>
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<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>Shannagh Bay Healthcare Limited</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Catherine Rose Connolly Gargan</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Mary O'Donnell</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>32</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 1 day(s).

The inspection took place over the following dates and times
From: 13 August 2018 07:45
To: 13 August 2018 16:00
From: 13 August 2018 08:00
To: 13 August 2018 16:00

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>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Governance and Management</td>
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<tr>
<td>Outcome 09: Statement of Purpose</td>
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<td>Compliant</td>
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<tr>
<td>Outcome 10: Suitable Person in Charge</td>
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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. Inspectors also followed up on progress with the action plan from the previous monitoring inspection in Nov 2017. The centre had come into compliance with two outcomes and the third action plan was in progress. Inspectors were informed that the installation of a fire proof mechanical lift was expected to be operational within a week of the inspection. Fire
safety and significant refurbishment works were referenced in two additional conditions of the centre's registration. The provider acknowledged that changes had been made to the refurbishment works in the plan submitted in August 2017, as referenced in condition 8. The provider agreed to submit an application to vary these conditions of registration following the inspection.

Inspectors followed up on unsolicited information received by HIQA (Health Information and Quality Authority) and found the concerns were not substantiated.

This is the second dementia thematic inspection carried out in the centre and significant improvements were found on 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) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The table above outlines the self-assessment and inspectors' judgments for each outcome.

Inspectors met with residents and staff members during the inspection. They tracked the journey of residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Inspectors also reviewed documentation such as care plans, medical records, staff rosters and training records.

Shannagh Bay is registered for 43 residents. On the day of the inspection, 10 of the 32 residents in the centre were formally diagnosed as having or were suspected of having dementia. The centre also accommodated 10 residents under 65 years with an acquired brain injury or other neurological conditions.

Efforts to create a warm homely environment for residents with dementia had been limited due to the major refurbishment works in progress. Rooms on the lower ground floor and some rooms on the upper floors had been refurbished to a good standard. Contrasting colours was not evident in the shower rooms and ensuite facilities, which would benefit residents with dementia and those with visual impairments. The rear of the premises was currently a building site and residents had no access to a secure, safe outdoor area. This was part of the planned extension and refurbishment works.

The daily routine was largely determined by the residents. Staff were sensitive to the needs of each resident and worked at an appropriate pace to support residents with dementia. Staffing levels and skill mix were appropriate and most of the staff demonstrated some degree of positive connective care in their interactions with residents. Inspectors found that the majority of staff interactions with residents were task focused. Although the management team discussed plans to revise the activity schedule, there was only one person available to facilitate activities. Groups were large and the range of activities did not take account of the age profile of the residents and the diversity of social needs which should be accommodated.

Matters requiring review are discussed throughout the report. The action plan at the end of the report contains actions that are required to be completed 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 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):
No actions were required from the previous inspection.

Findings:
Inspectors was satisfied that each resident's wellbeing and welfare was maintained by a good standard of nursing care and appropriate medical and allied health care. Residents were comprehensively assessed on admission and care plans were developed to meet their assessed needs. Staff supported residents and relatives to engage in the care planning process including end-of-life assessments but documentation did not adequately reflect this collaborative approach. Policies and procedures were in place to ensure that medication management, wound care and diabetic management was in line with professional guidelines and best practice.

Samples of clinical documentation were reviewed, which indicated that all residents were assessed prior to admission. The pre-admission assessment was generally conducted by the person in charge who looked at both the health and social needs of prospective residents. A care plan based on each resident's assessed needs was developed within 48 hours of admission. There was evidence that residents and their families, where appropriate, were involved in the care planning process, but the documentation relating to this required improvement. Following admission, the assessment process involved the use of validated tools to assess each resident's needs, including their risk of malnutrition, falls, level of cognitive impairment and their skin integrity. Detailed person-centred care plans were then developed to guide the care provided. Inspectors reviewed the care plans for residents who had diabetes and wounds. There was evidence that residents had access to specialist advice when required. Care plans were updated to reflect specialist advice and care provided was in line with local policies and best practice.

Improvement was required to strengthen the systems in place to ensure residents' nutritional and hydration needs were met. Residents were screened for nutritional risk on admission and reviewed on a four monthly basis thereafter. Residents had oral assessments and access to speech and language and dietetic services. However, inspectors were not assured that care plans were revised when there was a change in a resident's condition or when the goal of care was not being achieved. For example, to 'maintain the resident's weight', improvement was required to ensure that unintended
weight loss was identified and timely interventions were put in place. Systems also needed to be reviewed to ensure that specialist advice was communicated to the kitchen staff and to all staff who provided assistance to residents at meal times. The inspectors noted that individual preferences and habits around mealtimes were recorded. Meals were well presented with adequate menu choices available. It was noted that mealtimes were an unhurried social experience, with sufficient numbers of staff available to support residents as necessary in a discrete, caring and respectful manner. Several residents who met with inspectors commented positively about the food provided. Residents had been consulted as part of a nutrition project. The menu had been reviewed to include new dishes such as lasagne and more fish dishes.

Residents had access to GP services and out-of-hours medical cover. A full range of other services were available on referral, including mental health, physiotherapy, occupational therapy, podiatry and ophthalmic services. Inspectors found that residents’ records included results of consultations with allied health professionals.

There were several examples of good practice in relation to end-of-life care. While residents and their relatives were afforded the opportunity to outline their wishes regarding end-of-life care and procedures, inspectors identified some gaps in this documentation. The inspectors were satisfied that caring for a resident at end-of-life was regarded as an integral part of the care the service provided. The practices were supported by an end-of-life policy. The person in charge confirmed that the centre and residents received advice and support from the local palliative care team as necessary.

Medication management policies guided practice in relation to prescribing, storing and administering medications. The pharmacist undertook audits and was available to meet with residents as they wished.

Medications that required strict control measures (MDAs) were carefully managed and kept in a secure cabinet in keeping with legislation and professional guidelines. Nurses kept a register of MDAs. An inspector checked a sample of balances and found these to be correct. Checks were carried out by two nurses at the end of each shift.

A secure refrigerator was provided for medications that required specific temperature control. Inspectors noted that the temperatures were within acceptable limits at the time of inspection. There were appropriate procedures for the handling and disposal of unused and out-of-date medicines.

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

Findings:
There were policies and procedures in place to protect residents from being harmed or abused.

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, but some staff were unclear about the 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). Staff had received specific training in dementia care and the centre's local policy had been implemented. The inspectors reviewed residents' files and noted that a comprehensive assessment had been undertaken where required. Possible triggers for responsive behaviours had been identified and staff spoken with described the appropriately person-centred interventions that they use. During the inspection, staff approached residents with responsive behaviours in a sensitive and appropriate manner. The residents were observed to respond positively to the techniques used by staff. Inspectors saw that additional support and advice were available to staff from the psychiatric and rehabilitation services.

A restraint-free environment was promoted. The inspectors noted that appropriate risk assessments had been undertaken. Use of restraint was low and staff spoken with confirmed the various alternatives that had been tried, prior to the use of bedrails. Care plans were in place to guide practice and safety checks were completed when restraint was in use.

The provider was a pension agent for some residents and used a client account with transparent systems in place to safeguard residents' monies, in line with national guidelines. The provider did not manage comfort monies for residents.

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 were satisfied that residents were consulted on the organisation of the centre, and that their privacy and dignity was respected. Staff worked to ensure that each resident with dementia received care in a dignified way that respected their privacy. Care plans were in place to meet residents needs for social engagement. However, inspectors found improvement was required to ensure that activities available reflected the care plans and the capacity and interests of individual residents.

Inspectors observed staff interacting with residents in an appropriate and respectful manner, and it was clear that staff knew the residents well. Inspectors noted that frontline staff and management had established comfortable relationships with residents and the inspectors saw staff engaging with residents in conversations and fun. Interactions where a carer did not communicate with a resident while providing assistance was also observed.

Independent advocacy services were available and there were no restrictions to visiting in the centre. Residents were facilitated to exercise their civil, political and religious rights. Residents confirmed that their rights were upheld. Residents were satisfied with opportunities for religious practices. Arrangements were in place for residents to attend Mass in the centre on Sunday or to attend local services in the community.

As part of the inspection, the inspectors spent a period of time observing staff interactions with residents. The observations took place in the day room and the dining room. Observations of the quality of interactions between residents and staff for selected periods of time indicated that while some staff interacted with individual residents and demonstrated positive connective care, the majority of the interactions reflected task orientated care. These results were discussed with the management team at the feedback meeting.

There was a residents’ committee in operation. Inspectors viewed the minutes of some meetings and saw that suggestions made by residents had been taken on board. There was evidence that feedback on the services provided was sought from residents with dementia. Inspectors noted that the provider representative met regularly with residents and the person in charge met each resident on a daily basis to support residents with communication difficulties or those with dementia to share their views and discuss their concerns.

Information about individual resident’s hobbies and interests was gathered and care plans developed to meet each residents social and activation needs. However, inspectors found improvement was required to ensure that activities available reflected the care plans and the capacity and interests of individual residents. There was one activity co-ordinator and the range of activities on offer did not meet the diverse needs of the residents. Younger residents had limited opportunities to engage in age appropriate activities and opportunities to attend sporting events, community activities or other social events, such as going to the cinema. Attendance at group activities was too large for one activity co-ordinator to support the less able residents to engage in meaningful activities. It was evident from the care plans reviewed that there was a strong reliance on televisions and family to provide social engagement. Staff told inspectors that some
Residents went to a local café or pub and families sometimes take residents for a walk along the seafront.

Residents did not have access to a secure outdoor space, although the creation of a secure garden formed part of the refurbishment works. Grooming for female residents was an area also needing improvement. The hairdresser visited monthly and some residents said they would prefer to have their hair washed and styled more often.

**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:**
The complaints policy for the centre clearly outlined the different stages of the complaints investigation process. The complaints procedure was prominently displayed in the centre and clearly outlined the independent appeals process. The residents' guide also held details of the complaints policy and the independent appeals process. Contact details for the office of the ombudsman were included in the residents' guide.

The inspectors examined the feedback folder which contained compliments and a complaints log. Complaints were recorded and the results of the investigation process and actions taken on foot of a complaint were clearly laid out. The outcome of the complaint and the complainant's satisfaction with this outcome was recorded. Residents who spoke with the inspectors said the management team and staff were open to receiving complaints. Residents felt they could bring issues to them and that they would be resolved. There was evidence that complaints were used to inform service improvements.

**Judgment:**
Compliant

### Outcome 05: Suitable Staffing

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

Findings:
Inspectors was satisfied that there were appropriate staff numbers and skill mix to meet the assessed needs of residents taking into account the size and layout of the centre.

There was a recruitment policy in place. Inspectors reviewed a sample of staff files and found that they contained the information required by Schedule 2 of the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Assurance was given by the management team that Garda Síochána (police) vetting was in place for all staff and there was evidence of this in the files reviewed.

Inspectors saw that a robust induction programme was in place for new staff which included the provision of information to the staff member on issues such as confidentiality and policies and this was signed off once completed.

Up-to-date registration numbers were in place for nursing staff. An actual and planned roster was maintained in the centre with any changes clearly indicated. The inspectors reviewed the roster which reflected the staff on duty and noted that there were at least two nurses on duty in a 24 hour period. An audit of staffing based on the dependencies of residents had recently been carried out and actions were being progressed to recruit two senior carers to supervise and support care staff in the delivery of care to residents.

There were no volunteers in the centre at the time of inspection. The provider was aware of the requirements of the regulations in this regard.

The training records for all staff were reviewed and showed that a wide range of training was provided to staff in areas such as dementia and managing responsive behaviours. The person in charge was revising the training to ensure that staff were competent to support residents who had responsive behaviours. The majority of staff had attended mandatory training and training events were scheduled in August for new staff and staff who required refresher training.

Judgment:
Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The centre was originally a period home, and therefore the layout and design of the centre was not optimal to meet the needs of the residents. Upon the completion of planned renovations, the design and layout will promote the dignity, well-being and independence of residents with a dementia. For safety reasons, only mobile residents were accommodated on the lower ground floor and some of the residents on the top floor were also independently mobile.

In total, there are 14 single, 13 twin and one three bedded room. All bedrooms have an en suite toilet and wash-hand basin and some bedrooms have full ensuite facilities. There was a plan to refurbish all of the bedroom accommodation. Bedrooms on the lower ground floor and some bedrooms on the upper floors have been refurbished, appropriately decorated and equipped with modern and bright furnishings; including televisions and a resident alarm system. Bedrooms at the front allowed residents good sea views. Residents had adequate storage for their clothing and a safe lockable storage space. Most of the rooms were personalized with family photos and posters.

Further enhancements to the bedrooms would assist residents' orientation. This might include the use of clocks and calendars in bedrooms and additional directional signage and contrasting colours in communal areas throughout the centre.

Additional wheelchair accessible toilets were located around the building.

There was a fully equipped sluice room with appropriate shelving. There was adequate appropriate, assistive equipment such as profiling beds, hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames. Servicing was up to date for this equipment. Storage space for equipment was in short supply. A veranda adjacent to the day room on the ground floor was used to store all types of equipment while renovation works were in progress. Communal circulating areas had hand rails but corridors were not sufficiently wide for two wheelchairs to pass through. However all walkways were clear and uncluttered to ensure residents' safety when mobilising.

The back of the premises was a building site and staff told inspectors they used the public green across the road as an external area for residents to walk and sit outside. Residents also had access to a sun lounge but inspectors noted that the majority of residents spent the day in the large day room on the ground floor, where they also took their meals.

Parking was available to the front and side of the building.

**Judgment:**
Non Compliant - Moderate

### Outcome 07: Health and Safety and Risk Management

**Theme:**
Safe 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 well managed with clear arrangements in place to monitor the standard of care delivered to residents. There were clear systems to review the quality of care delivered, effective recruitment and training of staff and information for residents on the complaints procedure. While there was a clear contract for residents setting out the terms of their stay, improvement was needed to ensure transparency regarding the
The provision of toiletries for a fixed monthly fee. Toiletries were provided to the majority of residents in this manner, but itemised bills were not available.

The company directors participated in the governance and management of the centre on a daily basis. The provider had developed a clear management structure in the centre, and had delegated responsibilities to named people. For example clinical governance, facilities, and administration to ensure standards were maintained in all areas. Regular management meetings were held to ensure good communication and oversight of the service. The person in charge met with nurses to review practice in all areas and to share audit findings and promote learning.

Judgment:
Compliant

Outcome 09: Statement of Purpose

Theme:
Governance, Leadership and Management

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

Findings:
The Statement of purpose had been revised recently. It contained all the information required under Schedule 1 of the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Staff were familiar with the Statement of Purpose and it clearly set out the management structure, the facilities and the service provided.

Judgment:
Compliant

Outcome 10: Suitable Person in Charge

Theme:
Governance, Leadership and Management

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

Findings:
A person in charge had been appointed in March 2018. The person in charge was suitably qualified and had the relevant experience and qualifications for the role. There
were suitable arrangements in place for the management of the centre in the absence of the person in charge.

**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:**

Catherine Rose Connolly Gargan
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<td>OSV-0000095</td>
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<tr>
<td>Date of inspection:</td>
<td>13/08/2018</td>
</tr>
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<td>Date of response:</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 Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors were not assured that assessments were repeated and care plans reviewed when there was a change in a resident's condition or when the goal of care was not being achieved, e.g. to 'maintain the resident's weight'. Improvement was required to ensure that unintended weight loss was identified and timely interventions were put in place.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Systems needed to be reviewed to ensure that specialist advice was communicated to the kitchen staff and to all staff who provided assistance to residents at meal times.

1. **Action Required:**
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident’s family.

**Please state the actions you have taken or are planning to take:**
Dietician Referral sent for resident with unintentional weight loss and dietician referrals will be sent again if there is no improvement in residents weight. Reassessment and timely intervention for residents with unintentional weight loss will be ongoing. System is reviewed and a new system ie, a communication diary is in place to communicate the changes made by Dietitian and SALT to the kitchen staff. All other staff will be informed through daily hand over given by the coordinators. We will reiterate the importance, and stipulate that all family engagement in resident care be documented on going. The PIC will continue monitor the documentation and care plans goals and ensure all interaction made with family in the care of residents are documented.

The particular resident who was reviewed that day with unintentional weight loss was seen by the Dietician on 07/03/2018, which we weren’t able to find it on the day of inspection, details of reviewed can be forwarded to you, if you need clarification.

<table>
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<tr>
<td>Theme: Safe care and support</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Put systems in place to provide each resident with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.

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

**Please state the actions you have taken or are planning to take:**
A new system ie, a communication diary is in place to give information to the chef, to ensure residents dietary needs are addressed as prescribed by dietitian. The PIC will monitor the system ongoing. RGNs and care coordinators will ensure that residents who need fortified food are receiving it on a daily basis. Kitchen staff and care staff are aware of residents who need food fortification. Residents on food fortification will
continue to be provided with snacks in between their main meals and smoothies in the evening after their dinner.

**Proposed Timescale:** 07/09/2018

### 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:
Some staff were unclear about the reporting procedure for an allegation or suspicion of abuse.

3. **Action Required:**
Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

**Please state the actions you have taken or are planning to take:**
All staff receives Elder Abuse training upon commencement of employment and will attend safeguarding training as it is organised within the community. All staff have completed a refresher session on what they should do should they suspect or witness abuse. The flowchart in the reception area was again brought to their attention.

**Proposed Timescale:** 07/09/2018

### 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:
Provide residents with appropriate opportunities to participate in activities in accordance with their interests and capacities.

4. **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 activities programme is currently mid review with a fourth draft of a weekly and monthly programme completed. The PIC, GM, RGN, HCAs and Activities Co-ordinator are working to create a programme that encourages everyone to participate. With regards to some of our younger residents we are meeting with them as a group to discuss in more detail ideas that would suit their interests. Feedback from this meeting
will be incorporated into the programme.

**Proposed Timescale:** 02/11/2018

**Theme:**
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Residents expressed a preference for more frequent visits to the hairdresser.

5. **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:
Hairdressing is scheduled frequently, one to two times per month. Additional sessions can be arranged with the permission of NOKs

**Proposed Timescale:** 07/09/2018

**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:
The design and layout of the centre during refurbishment work did not promote the dignity, well-being and independence of residents with a dementia.

6. **Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

Please state the actions you have taken or are planning to take:
As the refurbishment programme continues, all bedroom doors are now a purple colour with bathroom doors and en-suites a blue colour, general doors / communal rooms are a green colour and areas that have restrictive access the doors are a red colour. More signs and picture signs will be placed around the nursing home detailing the specific area or room e.g. bathroom. Clocks will be purchased and placed in bedrooms. In the new year calendars will be purchased and placed in bedrooms also. As per our plans submitted to HIQA, the exterior garden and landscaping will commence upon completion of the building works.
**Proposed Timescale:** 31/12/2020

**Theme:**
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The premises did not conform with the matters set out in Schedule 6.
Arm chairs were worn and torn and needed to be upholstered or replaced.

7. **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:
All chairs have been re-inspected and those requiring it were replaced. Some armrests the leather has worn, we are currently having them reupholstered.

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**Proposed Timescale:** 30/11/2018

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

**Theme:**
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Records of fire evacuation drills were incomplete.

8. **Action Required:**
Under Regulation 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
All fire training including drill scenarios are completed with a report that was implemented in early 2017. This was done by the PIC and GM. 2 documents reviewed by the inspector were on duty informal trainings done by the staff nurses. From now on if staff nurses complete such trainings they too will complete the report and submit to the GM with an attendance sheet. On-going evacuation training and documentation will continue on a quarterly basis or more regularly where there are new employees or issues arising from drills.

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**Proposed Timescale:** 07/09/2018

**Theme:**
**Safe care and support**

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Replacement of some existing doors with fire rated doors was not completed.

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

**Please state the actions you have taken or are planning to take:**
Refurbishment, upgrade and development plan updated and sent to HIQA. Plan is a live document and is in constant review, and reflect the plans that were sent to HIQA on 02-08-2017. ALL current doors are fire rated but will be replaced with new colour fire rated doors. As mentioned the Inspection Report ALL fire doors were reviewed and approved earlier in the year for smoke seal and intumescent strips.

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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Installation of a mechanical fire proof lift to ensure residents' safe evacuation in the event of a fire necessitating evacuation from the lower ground to the ground floor level was not completed.

**10. Action Required:**
Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

**Please state the actions you have taken or are planning to take:**
Lift is operational and the GM and maintenance have received training on how to use the lift on a day to day basis and in the event of an emergency including fire evacuation mode. Insurance company have also inspected the lift and have logged the lift on their system. In 3-4 months both lifts will go through the bi-annual inspection. We are awaiting the Certificate of Conformity and final Commissioned Certificate which will be forwarded to HIQA once in our possession. The statement of purpose will also be updated to reflect all changes. Evacuation simulations (day and night scenarios) using the lift will commence and all staff will complete sessions until they confident and competent and documentation will be completed.

| Proposed Timescale: 30/09/2018 |