**Centre name:** Blair's Hill Nursing Home  
**Centre ID:** OSV-0000201  
**Centre address:** Blair’s Hill, Sunday’s Well, Cork.  
**Telephone number:** 021 430 4229  
**Email address:** patobrien09@yahoo.ie  
**Type of centre:** A Nursing Home as per Health (Nursing Homes) Act 1990  
**Registered provider:** Blair’s Hill Nursing Home Limited  
**Provider Nominee:** Patrick O’ Brien  
**Lead inspector:** John Greaney  
**Support inspector(s):** Noel Sheehan  
**Type of inspection:** Unannounced  
**Number of residents on the date of inspection:** 35  
**Number of vacancies on the date of inspection:** 2
About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 07 December 2017 10:30
To: 07 December 2017 18:00

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Substantially Compliant</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
Blair’s Hill Nursing Home is a three-storey building located in a cul-de-sac, off a busy street on the north side of Cork City. There is also a basement, which houses the main kitchen, staff facilities and other storage areas. Residents' bedroom accommodation is on the ground, first and second floors, which can be accessed by both stairs and lift. Most residents are accommodated in single bedrooms and there are two twin bedrooms.

This was a follow-up inspection and was conducted to ascertain if actions from the previous inspection were addressed satisfactorily. During the inspection, which was conducted over the course of one day, inspectors met with a number of residents, relatives and staff members, including the person in charge and the provider. Inspectors observed practices and reviewed records such as nursing care plans, medical records, accident and incident logs, policies and procedures and a sample of personnel files.
Overall, the findings of this inspection indicated that residents received care to a good standard. Residents to whom inspectors spoke stated that they were happy living in the centre and were complimentary of the care provided by staff. Staff members spoken with were knowledgeable of residents’ individual needs. Staff were seen to interact with residents in a caring and respectful manner. Residents received a comprehensive assessment on admission and care plans were developed in accordance with the findings of the assessments. Residents had good access to medical, specialist and allied health services and there was evidence of regular review.

Improvements were noted in the governance structure since the last inspection. New structures had been put in place, which included a clinical governance committee. Membership of the committee included the provider representative, the person in charge, an administrative staff member, nursing staff and care staff. The management structure now identified a person responsible for deputising in the absence of the person in charge. This person had recently been appointed and was undertaking a programme of education in relation to regulation in the social care sector.

While most of the actions from the previous inspection were satisfactorily addressed, some actions remained outstanding. For example, the provider continued to be a pension agent for a number of residents, and while there were adequate records in place in relation to lodgements and expenditure, the centre was not in compliance with department of social protection guidance in relation to the bank account into which the money was lodged.

Some improvements were still required in relation to infection prevention and control. At the last inspection it was identified that there was not an adequate protocol in place in relation to the sharing of hoist slings by residents. While a system had been put in place since the last inspection, it was not at all times adhered to by staff. Inspectors found a plastic basin in a bathroom that was soiled with dried up residue of unknown origin. It was also observed by inspectors that many of the communal toilets contained a urinal bottles and it was not clear what the purpose was of storing these bottles in the toilets.

Other required improvements included:
• the supervision of residents while smoking was not managed in compliance with the centre's own smoking policy
• not all staff had up-to-date training in responsive behaviour
• not all care plans had up-to-date reviews
• wound care plans could be enhanced through the use of photographs
• employment histories did not always contain an explanation for gaps in employment.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.
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 DesignatedCentres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

**Outcome 01: Statement of Purpose**
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
There was a statement of purpose that had been revised since the previous inspection. It accurately described the service that is provided in the centre and contained all of the information required by the regulations.

**Judgment:**
Compliant

**Outcome 02: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems and sufficient resources are in place to ensure the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
At the last inspection it was identified that action plans associated with audits did not identify a date for when actions should be completed or who was responsible for implementing the actions. On this inspection, inspectors found that there was a comprehensive programme of audits and a schedule of when each audit would be completed over a 12 month period. Completed audits included audits of hand hygiene, personnel records, infection prevention and control, dementia care, diabetes care,
pressure sore audit and an audit of complaints. Where required improvements were identified by the audit, there was an associated action plan outlining who was responsible for implementing the improvement and a date for when it should be completed.

Improvements were also noted in relation to management practices since the last inspection. New structures had been put in place, which included a clinical governance committee. Membership of the committee included the provider representative, the person in charge, an administrative staff member, nursing staff and care staff. The committee met monthly and discussed findings of audits and required improvements in the format of a HIQA inspection report. There was an action plan for each meeting identifying a person responsible for the action and a proposed completion date.

The management structure now identified a person responsible for deputising in the absence of the person in charge. This person had recently been appointed and was undertaking a programme of education in relation to regulation in the social care sector. As this person was new to the role, the person in charge was in the process of providing mentorship until the role was established and embedded in practice.

**Judgment:**
Compliant

**Outcome 03: Information for residents**

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

**Theme:**
Governance, Leadership and Management

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

**Findings:**
At the last inspection it was identified that the residents' guide did not contain the required information in relation to the centre's registration, the organisational structure of the centre or the complaints procedure. The residents' guide had been revised since that inspection and now contained all of the required information.

**Judgment:**
Compliant

**Outcome 05: Documentation to be kept at a designated centre**
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and
ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:
Governance, Leadership and Management

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

Findings:
At the last inspection it was identified that the Directory of Residents did not contain all of the information required by the regulations. On this inspection the Directory of Residents had been revised and now contained all of the required information. At the last inspection there was no policy on the provision of information to residents available in the centre. This policy was available in the centre on this inspection.

The provider and person in charge were requested to review residents' records in relation to the retrievability of information. Care plans contained a lot of historical information that could possibly be archived to allow for more up-to-date information to be easily accessed.

Judgment:
Substantially Compliant

Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe care and support

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

Findings:
There was a policy in place for the prevention, detection and response to abuse. At the last inspection it was identified that not all residents had received up-to-date training in recognising and responding to abuse, however training had been scheduled to take place following the inspection. On this inspection training records viewed by inspectors
indicated that this training had taken place and all staff now had up-to-date training. Staff members spoken with by the inspector were knowledgeable of what constituted abuse and what to do in the event of suspicions or allegations of abuse.

There were systems in place for the management of residents' finances. The centre held small sums of money for safekeeping on behalf of residents and adequate records were maintained of all transactions for and on behalf of residents. At the last inspection the provider was advised to consult with their bank in relation to the most appropriate method of managing the finances of residents for whom they were a pension agent, in order to be in compliance with department of social protection guidance. While the provider had consulted with their bank, inspectors were not satisfied that the centre was in compliance with this guidance. For example, the centre continued to manage money on behalf of residents but this was not held in a separate interest bearing account.

There was a policy in place for managing responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia). There were a number of residents in the centre on the days of inspection that presented with responsive behaviour. Based on discussions with members of staff, they had the knowledge and skills to appropriately respond to and manage incidents of responsive behaviour. While a significant number of staff had attended training in responsive behaviour since the last inspection, eight members of staff, from a complement of 42, had not attended this training.

A restraint free environment was promoted. The only form of restraint evident in the centre on the days of inspection was in the form of bedrails. Where bedrails were in place, there was a risk assessment completed prior to the use of restraint, and safety checks were completed while restraint was in place.

**Judgment:**
Non Compliant - Moderate

---

**Outcome 08: Health and Safety and Risk Management**

The health and safety of residents, visitors and staff is promoted and protected.

**Theme:**
Safe care and support

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

**Findings:**
There was a risk management policy that addressed all of the items required by the regulations. There was an up-to-date safety statement, which was signed and dated. Since the last inspection the risk register had been revised and now there was one definitive risk register for the centre, detailing risks and the controls in place to mitigate
At the last inspection it was identified that while there was an audit of accidents and incidents, the action plan associated with the audit did not include a timescale for completion. On this inspection it was found that all audits, including accident and incident audits, contained an action plan identifying who was responsible for implementing any required improvements and a timescale for when they should be done.

Improvements were noted since the last inspection in relation to infection prevention and control. There was a programme of cleaning and areas such as shower trays, grouted areas between wall tiles, wash hand basins and taps were now clean. A process was put in place whereby hoist slings were identified for individual resident use, rather than communal use as found on the last inspection. However, some improvements were still required in relation to infection prevention and control. For example, inspectors found that there were two hoist slings stored on top of each other on a hoist stored in a bathroom. Staff were unable to identify for which residents these hoist slings were intended. Also in this bathroom, inspectors found a plastic basin that was soiled with dried up residue of unknown origin. It was also observed by inspectors that many of the communal toilets contained a urinal bottles and it was not clear what the purpose was of storing these bottles in the toilets. Inspectors were not satisfied that this complied with recommended infection prevention and control practice. The wall tiles in one of the toilets were broken making it difficult to keep the surface clean.

Inspectors found suitable fire equipment was available throughout the centre. Fire evacuation procedures were prominently displayed. All staff had participated in mandatory annual fire training and regularly practiced drills. Staff spoken with were knowledgeable as to personal emergency evacuation plans for residents, the use of ski sheets, compartmentalisation and fire exits. A manual call point was tested on a weekly basis, followed by an inspection of door release mechanisms. A fire register was available which included records of completed in-house tests, including daily inspection of emergency exits and weekly inspection of emergency lighting and fire equipment. Maintenance records indicated the fire safety equipment was serviced annually and emergency lighting and the fire alarm were serviced quarterly.

A number of residents smoked in the centre. There was a designated smoking room and the door to the room was kept closed to minimise the escape of smoke to other parts of the centre. There was a fire blanket and fire extinguisher located proximal to the smoking room. There was also a closed circuit television (CCTV) camera located in the room and the viewing screen was located in the nurses office. There was a smoking policy to guide staff in relation to how to manage smoking in the centre by residents. The policy, however, stipulated that all residents were supervised while they were smoking, but that was not what was done in practice. Inspectors observed that a number of residents were smoking unsupervised in the smoking room. Each resident that smoked had a risk assessment completed to identify the level of supervision required while smoking and the safe level of access to cigarettes and lighters by residents. This risk assessment was updated since the last inspection and provided a more objective assessment of a resident's capacity to smoke independently. The provider and person in charge were requested to review the management of smoking in
the centre to ensure that what happened in practice was guided by an appropriate policy.

**Judgment:**
Non Compliant - Moderate

---

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

**Theme:**
Safe care and support

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

**Findings:**
It was identified at the last inspection that false alarms in the fire detection system were not notified. Records viewed by inspectors on this inspection indicated that all notifications were being submitted to HIQA as required.

**Judgment:**
Compliant

---

**Outcome 11: Health and Social Care Needs**
*Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based nursing care and appropriate medical and allied health care. The arrangements to meet each resident’s assessed needs are set out in an individual care plan, that reflect his/her needs, interests and capacities, are drawn up with the involvement of the resident and reflect his/her changing needs and circumstances.*

**Theme:**
Effective care and support

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

**Findings:**
Overall, residents appeared to be generally well care for and their health needs were met to a good standard. Residents had access to GP services and the majority of residents were under the care of one GP, however, choice of GP was available. The GP visited the centre regularly and there was evidence of on-going review. There was also access to out-of-hours GP services.
Residents had access to the services of a physiotherapist that visited the centre every two weeks to support residents to maximise their independence in relation to mobility. The physiotherapist provided group activity sessions but also carried out individual assessments as required. Dietetic, speech and language therapy (SALT) and wound care services were provided by a nutritional supply company and were available on a referral basis. A visiting dental service offered annual assessments to residents and a visiting optician service, visited every two years.

Residents received a comprehensive assessment on admission and at regular intervals thereafter. Evidence based assessment tools were used for issues such as the risk of developing pressure sores, dependency levels, and the risk of falling. At the last inspection it was identified that, even though residents were weighed regularly and were monitored for weight loss, an evidence-based tool was not used to assess residents for the risk of malnutrition. This was now in place, and from a sample of records reviewed, all residents had this assessment completed. Care plans were developed for issues identified on assessment and these were personalised. However, some improvements were also required in relation to care planning. For example, the centre were in the process of updating care plans and many of the newly updated plans were person centred and provided good guidance on the care to be delivered. However, the care plan for one resident did not contain the most recent guidance or advice on care to be delivered, such as, for example, that provided by allied health professionals. The date written in the care plan indicated that this care plan was most recently reviewed in July 2016.

While there was evidence of good practice in relation to wound management, such as regular scientific assessments of wound and documented dressing changes, the process could be enhanced through the use of photographs to support the ongoing assessment of wounds.

There was evidence of the involvement of palliative care services for residents that approached end of life and there was evidence of the discussion of end of life preferences. There was documented evidence that residents and/or their relatives were involved in the development of care plans and this was supported by discussions with residents and relatives.

**Judgment:**
Substantially Compliant

---

**Outcome 12: Safe and Suitable Premises**

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

**Theme:**
Effective care and support
**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Blair's Hill Nursing Home is a three-storey building located in a cul-de-sac, off a busy street on the north side of Cork City. There is also a basement, which houses the main kitchen, staff facilities and other storage areas. Residents' bedroom accommodation is on the ground, first and second floors, which can be accessed by both stairs and lift. 33 of the bedrooms are single rooms and there are two twin bedrooms. 30 of the bedrooms are en suite with toilet and wash hand basin. There are eight residents accommodated in single rooms in each of the first and second floors and the remaining residents are on the ground floor.

Overall, on the days of the inspection the centre was bright and generally in a good state of repair. The entrance porch lead to a conservatory style sitting room which was comfortably laid out with leather chairs, pillows, blankets and side tables. Large fish tanks occupied by exotic fish provided a focal point. The nursing home itself was set high against a stone cliff face. One side of the dayroom was fitted with large panels of glass, looking out onto a veranda and taking advantage of the views of the city below. The veranda could only be used by residents while being supervised by staff as it was not enclosed.

There were two small dining rooms located on either side of the nurses' office. Bedrooms were suitably spacious and most had been personalised with residents' personal property and possessions. There was adequate storage in the bedrooms for residents' clothes. There was adequate car parking at the front of the building.

A number of improvements were required following the last inspection and these had been satisfactorily addressed. Open access to the bottom of the stairwell on the ground and first floors had been through unsecured swing gates. Coded locks had been applied to these gates and the stairs was not accessible without the code. Records of preventive maintenance of equipment now included hoist slings in the maintenance programme. While there was a programme of preventive maintenance of equipment such as hoists and beds, there was no register maintained of beds in the centre or a record of when preventive maintenance was carried out on beds.

There were adequate sanitary facilities and there were bathrooms conveniently located for residents whose bedrooms were not en suite. At the last inspection it was identified that some toilets were not fitted with locks to support residents to maintain their privacy. Locks were now in place on all toilets.

**Judgment:**
Substantially Compliant

---

**Outcome 13: Complaints procedures**
The complaints of each resident, his/her family, advocate or representative,
and visitors are listened to and acted upon and there is an effective appeals procedure.

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

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

**Findings:**
There was a complaints policy that identified the process for managing complaints and who was responsible for addressing complaints. Inspectors reviewed the complaints log that demonstrated that complaints were being recorded and action was being taken in response to any complaints made. The satisfaction or otherwise of the complainant was also recorded. Since the last inspection complaints were now included in the audit process as a means of identifying trends and opportunities for improvement.

**Judgment:**
Compliant

**Outcome 16: Residents' Rights, Dignity and Consultation**
Residents are consulted with and participate in the organisation of the centre. Each resident’s privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

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

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

**Findings:**
Residents were facilitated with choice in relation to their daily routine. Inspectors observed that residents chose where and when to have their breakfast and one resident was seen partaking of breakfast in the dining room at approximately 11am on the day of the inspection. Visitors were seen to come and go throughout the inspection, and they appeared to be familiar with staff and staff were familiar with visitors. Separate facilities were available for residents to receive visitors separate from the day room and bedrooms. Residents had the option of locking their bedroom doors but management had access to a master key in the event of an emergency. The centre organised an activities programme to entertain and stimulate residents, which included activities facilitated by external groups and individuals at no extra cost to residents.
Staff were aware of the communication challenges of some residents and knew how to cater for visually impaired residents. At the last inspection this was not clearly highlighted in care plans. On this inspection, in the sample of care plans reviewed, improvements were noted in the documentation of communication needs.

The centre displayed a poster for advocacy services, including contact details, in the day room. Since the last inspection, contact had been made with the advocacy service. A volunteer had assumed the role of advocate and had completed advocacy training.

**Judgment:**
Compliant

---

**Outcome 18: Suitable Staffing**
There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

---

**Theme:**
Workforce

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

**Findings:**
Based on inspection findings, inspectors were satisfied that the centre had sufficient staff with appropriate skills, qualifications and experience to meet the assessed needs of residents and the size and layout of the designated centre during the day and at night. At the last inspection the provider was requested to review staffing in relation to the length of time it took to administer medications in the morning, when there was only one staff nurse on duty. Following this, the provider scheduled an additional nurse to work each morning.

Inspectors reviewed a sample of staff files to determine if staff were recruited in accordance in line with the requirements of Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. While most of the requirements of the regulations were in place, there were gaps in the employment history for a number of staff for which there was not a satisfactory explanation recorded. This action is addressed under Outcome 5 of this report. All staff nurses had up-to-date registration with An Bord Altranais agus Cnáimhseachas na hÉireann.

Mandatory training was provided for staff relevant to the area in which they worked. All
staff had successfully completed evacuation and fire drill training within the last year, and were familiar with what to do in the event of a fire. Most staff had attended manual handling training, however, a small number required this training. A programme of training had been undertaken since the last inspection and most staff had received up-to-date training in recognising and responding to abuse, responsive behaviours and infection prevention and control.

**Judgment:**
Substantially Compliant

---

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

John Greaney  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority
Provider’s response to inspection report\textsuperscript{1}

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Blair’s Hill Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000201</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>07/12/2017</td>
</tr>
<tr>
<td>Date of response:</td>
<td>04/01/2018</td>
</tr>
</tbody>
</table>

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 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While most of the requirements of the regulations were in place, there were gaps in the employment history for a number of staff for which there was not a satisfactory explanation recorded.

1. Action Required:
Under Regulation 21(1) you are required to: Ensure that the records set out in

\textsuperscript{1}The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:
Employment history of all the staff is currently being assessed for any gaps in their employment CV. Those that do have gaps are being asked to provide us with these as soon as possible. We are expecting to have these completed by January 12th.

Proposed Timescale: 12/01/2018

Theme:
Governance, Leadership and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The provider and person in charge were requested to review residents’ records in relation to the retrievability of information. Care plans contained a lot of historical information that could possibly be archived to allow for more up-to-date information to be easily accessed.

2. Action Required:
Under Regulation 21(6) you are required to: Maintain the records specified in paragraph (1) in such manner as to be safe and accessible.

Please state the actions you have taken or are planning to take:
Each Resident will now have second file which will be kept in locked cupboard near nurses station and all excess files that are not needed for the current care of Residents will be held in these files which will be easily retrievable if and when required. New Shelving with locked doors will have to be installed and this will take time. Expected date to be completed by 6th April 2018.

Proposed Timescale: 06/04/2018

Outcome 07: 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:
While a significant number of staff had attended training in responsive behaviour since the last inspection, eight members of staff from a complement of 42 had not attended this training.

3. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour
that is challenging.

Please state the actions you have taken or are planning to take:
A training class on responsive behaviour has been organised with St Luke’s on 17th January for the staff who were not able to attend last session.

Proposed Timescale: 17/01/2018
Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While the provider had consulted with their bank in relation to being a pension agent, inspectors were not satisfied that the centre was in compliance with department of social protection guidance in relation to the management of finances. For example, the centre continued to manage money on behalf of residents but this was not held in a separate interest bearing account.

4. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
The provider is no longer a pension agent for any of Residents as from the 1st of January 2018, family have been asked to take over their finances. However one Resident will now be collecting her own pension and will be in charge of her own finances. An account has been sought for her in Sunday’s Well Post office, we are waiting for the Department of Social Protection to confirm this.

Proposed Timescale: 30/01/2018

Outcome 08: 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:
Some improvements were still required in relation to infection prevention and control. For example:
• inspectors found that there were two hoist slings store on to of each other on a hoist stored in a bathroom. Staff were unable to identify for which residents these hoist slings were intended
• inspectors found a plastic basin in a bathroom that was soiled with dried up residue of unknown origin
• it was also observed by inspectors that many of the communal toilets contained a
urinal bottles and it was not clear what the purpose was of storing these bottles in the toilets.
• the wall tiles in one of the toilets were broken making it difficult to keep the surface clean.

5. Action Required:
Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

Please state the actions you have taken or are planning to take:
1. Hoist slings:
Previously we had room numbers on the hoist slings for identification but this has not worked out well so we now are having names tags put on each sling, also the name of the Resident for which each sling is being used will be put over each hanger where they will be kept while the Resident is up. We will also draw up a policy and procedures as part of our Infection control. We will have a meeting with all staff and a copy of these new procedures will be given to each staff member. This will be followed up the monthly governance meetings for six months. First meeting will take place on 23/01/18.

2. With regards to plastic basin found with soiled dry residue, we have spoken with all staff about this finding and the seriousness of this and the huge infection hazard and the impact it could have on the Residents and staff lives. A daily check will be made to prevent this from happening again. This will be added to the daily cleaning check list, and cleaning staff to sign format to confirm this. Infection control will be highlighted in all clinical governance meetings for the next six months.

3. All the urinals have been removed from communal toilets.

4 Broken tiles found in the toilet by nurses station will be replaced by 30/01/18

Proposed Timescale: 30/01/2018

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation to the management of smoking. For example, the smoking policy stipulated that all residents were supervised while they were smoking, but that was not what was done in practice. The provider and person in charge were requested to review the management of smoking in the centre to ensure that what happened in practice was guided by an appropriate policy.

6. Action Required:
Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.
Please state the actions you have taken or are planning to take:
The management of smoking policies and procedures has now been reviewed and new policy drawn up. A list will now be kept of those that smoke and a daily reference made at morning shifts which will be updated if any changes occur.

Proposed Timescale: 12/01/2018

**Outcome 11: Health and Social Care Needs**

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Wound care assessments could be enhanced through the use of photographs as part of the assessment process.

**7. Action Required:**
Under Regulation 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person’s admission to the designated centre.

Please state the actions you have taken or are planning to take:
Meeting with nurses with regards to wound assessment and the benefits of enhancing this through the use of photographs took place. This has already begun.

Proposed Timescale: 04/01/2018

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Some improvements were required in relation to care planning. For example, the care plan for one resident did not contain the most recent guidance or advice on care to be delivered, such as, for example, that provided by allied health professionals. The date written in the care plan indicated that this care plan was most recently reviewed in July 2016

**8. 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:
We have discussed these findings with the Nurses, and to ensure that all care plans are
fittingly updated as per regulations every 4 months a nurse has been nominated to specifically check all the Residents files that they are updated accordingly.

**Proposed Timescale:** 04/01/2018

**Outcome 12: 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:**
While there was a programme of preventive maintenance of equipment such as hoists and beds, there was no register maintained of beds in the centre or a record of when preventive maintenance was carried out on beds.

**9. 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:**
A Beds Preventive Maintenance Register has been put in place, also a Beds Faults Record has now been introduced, where all faults will be recorded on daily basis.

**Proposed Timescale:** 12/01/2018

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Most staff had attended manual handling training; however, a small number required this training.

**10. 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:**
A Manual Handling training has been organised on 24/01/18

**Proposed Timescale:** 24/01/2018