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:	Blackrock Abbey Nursing Home
Centre ID:	OSV-0000118
Centre address:	Cockle Hill, Blackrock, Dundalk, Louth.
Telephone number:	042 932 1258
Email address:	seamus@talbotgroup.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Orkcalb Unlimited Company
Provider Nominee:	Seamus O'Shea
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Vincent Kearns
Type of inspection	Unannounced
Number of residents on the date of inspection:	57
Number of vacancies on the date of inspection:	3

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:	To:
05 September 2017 08:00	05 September 2017 17:00

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

Outcome	Our Judgment
Outcome 02: Governance and Management	Non Compliant - Major
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Substantially Compliant
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Major
Outcome 18: Suitable Staffing	Non Compliant - Major

Summary of findings from this inspection

This was an unannounced inspection completed to monitor regulatory compliance and to follow up on progress with completion of the action plans from the last inspection in February 2017. While inspectors found that four of the eight actions required were satisfactorily completed and the remaining four actions were progressed, there was repeated areas of noncompliance with the regulations from previous inspection and are restated in this inspection report. The action plan to transition 13 residents to new community based purpose-built accommodation by 31 August 2017 had not been achieved. Significant non compliances were found in relation to the care and welfare of these residents and inspectors were concerned that the improvements found on the previous inspection had not been sustained.

The centre's statement of purpose states that the overall objective of the service is 'To provide a person-centred approach, empowering and supporting residents to be as independent as possible and to live meaningful and fulfilling lives'. The findings of this inspection did not provide sufficient assurance that this objective was achieved particularly in relation to residents with high levels of support needs and required frequent support/assistance with all their activities of living, including self-care and social support needs. Inspectors noted that a number of these residents who had

complex specialist needs also had sensory impairments, sensory processing difficulties and physical or mental health problems. The provider acknowledged that the current arrangement was not adequate to meet these residents' needs and stated that this aforementioned transition plan had not been progressed due to a lack of funding.

The centre is a two-storey premises and residents were accommodated on both floors. Communal accommodation for residents on the ground floor consisted of one communal sitting/dining room, one sitting/activity room and a small dedicated activity room. Residents' accommodation on the first floor consisted of a large dining room, a small sitting/dining room, two sitting rooms and a conservatory with seating provided. Accommodation for 30 residents was provided on each floor. All bedrooms on the ground floor were single occupancy and bedrooms on the first floor were single and twin occupancy. The design and layout of the premises continued to be inadequate to meet the individual or collective needs of residents with complex needs.

Inspectors spoke with residents, relatives and staff members. They observed practices and reviewed documentation such as care plans, accident and incident records, medical and nursing records, policies and procedures and staff files. Residents and relatives spoken with were generally positive in their feedback and expressed satisfaction with the facilities, services and care provided. However, staff expressed concerns that due to insufficient staff resources they were unable to provide an adequate standard of care to residents. Inspectors found that while staff were knowledgeable regarding residents' care needs, there was insufficient staff on duty provide timely assistance or to meet the social and personal care needs of residents.

The provider representative and person in charge were responsible for the governance, operational management and administration of services. Inspectors found that most residents' health care needs were met and that they had satisfactory access to medical services and allied health professionals. However the management team did not have effective systems in place to build on progress made and support continuous quality improvement. Many of the improvements found on the announced inspection in Feb 2017 were not sustained. Given the history of repeated non compliances found on previous inspections in 2016 in relation to governance and management, safeguarding, staffing and residents' rights, privacy and dignity, together with the major non compliances found on this inspection in relation to staffing and residents' rights, privacy and dignity, a judgment of major non-compliance was merited for governance and management.

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

Theme:
Governance, Leadership and Management

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

Findings:
With the exception of the announced registration inspection in February 2017, judgments of non compliance have been repeatedly found in relation to the governance and management of this centre. The centre's governance and management structure was revised following an inspection in September 2016 to ensure improved oversight of the service by the provider. However, findings on this inspection indicated that improvements found on announced inspection in February 2017 had not been sustained and this had a negative impact on residents' care and quality of life. The centre's statement of purpose states that the overall objective of the service 'is to provide a person-centred approach, empowering and supporting residents to be as independent as possible and to live meaningful and fulfilling lives'. The findings of this inspection did not provide sufficient assurance that this objective was achieved.

Systems for monitoring the standard and safety of care, the service provided and the quality of life for residents were in place and inspectors found that key aspects of the service and clinical care parameters were reviewed. Findings from the last inspection in February 2017 indicated that the provider had commenced implementing a computerized software programme to assist them with monitoring the quality and safety of key aspects of the service and to inform proactive quality assurance programme in the centre. A comprehensive review of the quality and safety of the service was completed in July 2017. Although timescales for completion of a number of areas requiring improvement were not clearly indicated, there was evidence that some improvement plans had been progressed. Many areas of non-compliance with the regulations found on this inspection were reflected in the findings of the quality and safety review undertaken by the provider in July 2017. However, inspectors found that improvements made were not sustained and monitoring systems were not sufficiently robust to inform quality improvements in relation to the quality and safety of the service

and quality of life of residents in the centre.

The provider was progressing the transition of 13 residents with complex needs to purpose built, community accommodation. However, the proposed date for completion of this process of 31 August 2017 was not achieved. Although a transition committee was established and consultation was evident with residents' families, the inspectors were not assured that the consultation process was meaningful and inclusive. This is discussed under outcome 16.

The management team did not have effective systems in place to build on progress and support continuous quality improvement. Many of the improvements found on the announced inspection in Feb 2017 were not sustained. Inspectors found the staffing resources were not sufficient to ensure the effective delivery of residents' care and quality of life in line with the centre's statement of purpose. Given the history of on-going non compliances found on previous inspections in 2016 in relation to governance and management, safeguarding, staffing and residents rights, privacy and dignity together with the major non compliances found on this inspection in relation to staffing and residents' rights, privacy and dignity, a judgment of major non-compliance was merited for this outcome.

Judgment:
Non Compliant - Major

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:
Inspectors found that there were some measures in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Inspectors found that peer-to-peer incidents or incidents of bruising of unknown origin were appropriately investigated. A restraint free environment was promoted but further improvement was necessary to ensure the use of bedrails was in line with national restraint guidelines to safeguard residents.

A restraint free environment was promoted in the centre since the last inspection and the number of bedrails in use was reduced. Each resident requiring restraint had an

assessment completed to confirm their need for bedrails or a lap belt and to ensure their safety when restrictive equipment was in use. Inspectors observed that routine safety checks were completed and documented when lap belts were in use. Although the frequency of safety checks was indicated when bedrails were in use, safety checks were incomplete for some residents as confirmed by gaps in their checking records. While there was evidence that staff were ensuring that the periods bedrails and lap belts were in use was minimized, residents' records did not indicate this practice was consistently implemented.

Staff were facilitated to attend training on identifying and responding to incidents, suspicions or disclosures of abuse of vulnerable adults. There was a policy in place which gave guidance to staff on the prevention, detection and management of any abuse. Staff spoken with demonstrated sufficient knowledge of the different forms of abuse of vulnerable adults. They were clear on their responsibility to report and the reporting procedures in the centre. Staff confirmed that there were no barriers to raising issues of concern. There were systems in place to ensure allegations of abuse were fully investigated and pending such investigations, measures were in place to ensure the safety of residents. Residents spoken with during the inspection were satisfied with the level of care they received and confirmed that they felt safe in the centre. Interactions between staff and residents were observed to be respectful and supportive.

Some residents were predisposed to episodes of responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Residents presenting with responsive behaviours were appropriately referred and reviewed by specialist medical services such as psychiatry and psychology services. Behavioural support care plans were developed for residents in each case. The behavioural support care plans reviewed informed proactive and reactive strategies which were person-centred. A small number of residents were administered psychotropic medicines on a PRN (a medicine only taken as the need arises) basis to de-escalate responsive behaviours when all other interventions failed. Arrangements were in place to review the use of this medicine in each case. Inspectors observed that a number of residents with complex support needs had sensory impairments, sensory processing difficulties and physical or mental health problems. Inspectors observed that some residents in the communal room on the ground floor displayed responsive behaviors including self-injurious behaviours and found that inadequate staffing contributed to the inadequate protection of vulnerable residents. For example, inspectors observed that there were a number of periods of the day when there was only one staff member available in this communal room to provide support for up to 17 residents with these complex needs. Inspectors observed that at times some residents were shouting out while others were engaged in responsive behaviours. Having only one staff member was not adequate to meet these residents' individual or collective needs. Staff spoken to confirmed that particularly during certain busy times, there was only one staff available in this communal room. The provider acknowledged that the current arrangement was not adequate to meet these residents' needs and stated that this aforementioned transition plan had not been progressed due to a lack of funding.

Management of residents' finances was found to be compliant with the regulations on the last inspection in February 2017 and were not re-examined on this inspection. The

findings from inspection in February 2017 indicated that the process and procedures for management of residents' monies was robust and transparent.

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

Findings:
Inspectors found the health and safety of residents, visitors and staff was promoted and protected. However improvements were required in relation to the identification and assessment of hazards and controls in place to mitigate risk.

The environment was kept clean and was well maintained. While there were measures in place to control and prevent infection, residents who required assistance of a hoist to support their moving and handling needs were not provided with individual slings. This issue was raised at a staff meeting on 09 August 2017. Staff completed hand hygiene procedures as necessary. Audits were carried out to ensure compliance with infection control procedures. Open shelf storage of utilities such as hand towels in the cleaning room and uncovered toilet rolls in communal toilets as found on the last inspection in February 2017 were satisfactorily addressed to mitigate risk of cross infection.

There was a health and safety statement in place. The risk management policy met the requirements of the regulations. However a number of hazards found on inspection were not appropriately risk assessed with controls implemented where necessary to mitigate the potential for occurrence. For example:
- A stairs with an open stairwell had a railing fitted which was not risk assessed to ensure it offered sufficient protection from fall to vulnerable resident and others.
- A balcony located on the first floor had a railing fitted on a low wall around the perimeter was not risk assessed to ensure it offered sufficient protection from fall to vulnerable resident and others.
- Personal protective equipment such as gloves and aprons stored in dispensers on both floors were accessible to vulnerable residents. Access to this equipment was not risk assessed to ensure it did not pose a choking hazard to vulnerable residents or others was not completed.

Procedures for fire detection and prevention were in place. Service records indicated that the emergency lighting and fire alarm system were serviced on a three-monthly and annual basis. Fire exits were regularly checked and were unobstructed. The fire alarm

system was in working order. There was evidence of evacuation drills taking place and all staff were facilitated to attend training in fire safety and to participate in an evacuation drill. Staff spoken with were clear on the procedure they would follow in the event of a fire. A wooden shelter erected for residents who smoked on a balcony on the first floor was replaced with a more robust structure that provided residents who used it with improved shelter from inclement weather conditions. Risk assessments were completed for residents who smoked to ensure their safety needs were met. A fire extinguisher and specialised apron to protect vulnerable residents was provided. Although a window was fitted in the new structure to facilitate staff to supervise residents using the facility, this did not permit sufficient view of residents. An emergency call-bell was not available at this this location to alert staff. This finding is actioned in outcome 12.

All residents had a personal emergency evacuation plan (PEEP) which considered the mobility status of each resident, their assistive equipment needs and the number of staff required to safely evacuate them. The information in the PEEPs did not consider the cognitive status and behaviours that required consideration should an emergency evacuation be necessary.

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that an allegation of abusive behaviour towards a resident by a staff member was not notified to the Health Information and Quality Authority (HIQA) as required. There was evidence of a timely investigation by the provider and the allegation was not substantiated. The provider notified this incident to HIQA following the inspection.

All other notifiable events including incidents or accidents where residents were injured were submitted as required. Quarterly notification of specified information was also submitted as required.

Judgment:
Substantially Compliant

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

Theme:
Effective care and support

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

Findings:
Inspectors found the healthcare needs of residents were met. Actions required from the previous inspection referenced substandard findings in relation to behaviour support care planning and incomplete policies to guide care of residents who sustained a fall and care of residents' wounds. Inspectors found that behaviour support care plans developed to support residents predisposed 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) were appropriate. They identified the relevant behaviours and informed the proactive and reactive interventions to prevent or de-escalate behaviours. The centre's falls management policy had been revised since the last inspection. Inspectors examined incident records and noted that staff undertook neurological observations to out rule the risk of a head injury following a fall as necessary.

Residents' care documentation was stored on a computerised data management system. This system was password protected to protect residents' personal information. Inspectors found that residents' needs were assessed by use of a variety of accredited assessment tools. All residents' needs were addressed with care plans that detailed their needs and the interventions that must be completed in each case in the sample of residents' records reviewed by inspectors. While there was evidence of improved consultation with residents or their families regarding care plan development and reviews thereafter, this information was inconsistently recorded. Inspectors also found that some care plans were generic and not person-centred. Residents' records indicated that they received timely access to healthcare expertise from the multidisciplinary team as required and their care plans were updated to include recommendations as necessary.

There were two residents that had developed pressure-related skin injuries in the centre. Care of wounds and pressure prevention management procedures were reviewed and inspectors found that improvements identified at the previous inspection had been sustained and embedded in practice. These improvements had a positive impact on residents' care and inspectors saw residents assessed as being at risk of or who developed pressure ulcers were being closely monitored and wounds were

appropriately managed. While management of residents' wound care in the centre reflected best practice procedures, a comprehensive up-to-date wound care policy was not available to staff in the centre. Inspectors were told that an up-to-date wound care policy was in draft format. This finding was an action required from the last inspection and is restated in the action plan from this inspection.

Inspectors found that there was a low incidence of injuries recorded from falls in 2017. Each resident was assessed on admission and regularly thereafter for risk of falling. Since the last inspection, improvements were implemented in management and care procedures for residents who sustained a fall. Neurological assessment observations were completed in each case as advised by the centre's updated falls management policy. Residents' care plans were also updated as necessary. Fall incidents to residents were reviewed each month by the person in charge and the clinical management team. A falls prevention and management audit was also completed since the last inspection and indicated that there were areas requiring improvement. However those areas or the remedial actions to address these areas were not outlined in the auditing system compliance report available. This finding is discussed and actioned in outcome 2.

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

Findings:
The centre accommodates a maximum of 60 residents in 44 single bedrooms (14 of which had en-suite toilet, shower and wash-basin facilities) and eight twin en-suite bedrooms over two floors. The size and layout of bedrooms was suitable to meet the needs of residents and there was sufficient toilet and washing facilities located at convenient intervals and within close proximity to communal areas. The positioning of residents' televisions in twin bedrooms had been reviewed to ensure both residents could view the television. The centre was clean, bright, well ventilated and warm. Since the last inspection, the layout of furniture in the communal dining room on the first floor had been altered to improve the circulation space available to residents. Inspectors observed that the dining room on the first floor was spacious and the rearrangement of

dining tables ensured that access through doorways was not hindered.

While there was a number of sitting areas available on both floors in the centre, the arrangements and layout of sitting and dining facilities on the ground floor did not meet the needs of all residents. The design and layout of the ground floor sitting room continued to be inadequate to meet the individual or collective needs of residents living there. For example, inspectors observed that up to 14 residents with maximum dependency needs shared this sitting room for most of their day. Inspectors observed that many of these residents had an intellectual disability with a multitude of support needs. They required frequent support/assistance with all their activities of living including self-care and social support needs. Inspectors noted that a number of these residents also significant sensory impairments, sensory processing difficulties and physical or mental health problems. Some residents also displayed responsive behaviors including self-injurious behaviours while in this communal room. Inspectors observed that this accommodation arrangement impacted significantly on the quality of life for these residents as this communal sitting/dining room on the ground floor was at times very noisy, crowded and unsuitable for residents with such complex care needs. By accommodating up to 14 residents with such needs in this sitting room ensured that residents privacy and dignity needs were not adequately met. This finding was discussed and actioned in outcome 16. There was also an absence of suitable comfortable seating provided to meet the needs of older residents in the communal rooms on the ground floor. Subsequently a number of residents on the ground floor chose to rest and dine in their bedrooms throughout the day of inspection.

A passenger lift was available between the ground and first floors and a small number of residents were seen by inspectors using it at will or with support by staff. The first floor was also accessible from a roadway located at the same level at the back of the centre. An internal secure and safe garden area was readily accessible from the ground floor. A balcony area was provided for use by residents on the first floor. However, as found on previous inspections, access to this area was restricted for all residents and was controlled by staff. While a protective railing was in place along the perimeter of the balcony, a risk assessment was not completed to ensure this control sufficiently mitigated risk of residents or others falling.

A storage room on the first floor was available for residents' equipment and the room was observed to be accessible. However, equipment such as hoists, assistive chairs and laundry trolleys were stored in annexed areas on corridors on both floors.

Judgment:
Non Compliant - Moderate

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:
A record of complaints received was maintained. The complaints procedure was displayed and was set out in an accessible format to meet the needs of some residents.

There was a designated complaints officer. There was evidence of timely and appropriate investigation and communication to complainants. An appeals process was in place. One complaint was recorded since the last inspection in February 2017. Investigation of this complaint was underway on the day of inspection. Arrangements were put in place since the last inspection to ensure complainants' satisfaction with the outcome of investigations was recorded. If dissatisfied, complainants were referred to the appeals process in the centre.

Residents spoken with told inspectors that they could freely express any dissatisfaction they had with the service provided and they believed that they would be listened to.

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:
Although improvements in meeting residents' social, emotional and recreation needs had been identified on the last inspection in February 2017, inspectors' findings on this inspection indicated that these improvements were not sustained. These findings did not provide assurances that activities that promoted the health, wellbeing and social needs of each resident was integral to their lives in the centre.

There was insufficient opportunity for residents on either floor to participate in activities in accordance with their interests and capabilities. Residents with complex needs and high support requirements who resided on the ground floor did not have adequate

opportunity or facilities provided to meet or support their social, occupational and recreational needs. The staffing arrangements observed on the ground floor was inadequate for staff to engage socially with residents. One activity coordinator facilitated activities for a small number of residents in an activity room on the ground floor. A few residents in the ground floor communal room were provided with hand massage by a member of staff. At any time there was one staff member in the communal room with residents during the day, and up to three on occasions. However, there were up to 17 residents with mostly assessed maximum dependency needs sitting, lying or standing in this communal sitting room and being supervised by one member of staff on many occasions throughout the day of inspection. As some residents were engaging in shouting, self-injurious behaviours and standing for prolonged periods; the one staff member was unable to sufficiently meet their individual or collective needs with appropriate support, intervention or diversion.

Although an exercise programme, music, a sing along and ball games was scheduled for residents on the first floor on the afternoon of the day of inspection, it was not provided. Other than background music playing for 15 residents in one communal sitting room on the first floor, none of the scheduled activities took place. Inspectors observed that while two to three residents read their newspapers, many other residents appeared to be disengaged or asleep. A sample of residents' activity participation records were examined by inspectors and most indicated that residents including residents who were unable to leave their bedrooms independently had not participated in any activities in the two days previous to the inspection. One resident went to a day service a number of days per week and he told inspectors that he liked going there and spoke about the activities he engaged in. While a maximum of two other residents went on an outing each Friday, none of the residents who were due to transition to houses in the community had appropriate access to a day service, voluntary groups or community resources and events. An interactive floor mat provided for residents on the ground floor was not functional. This finding is actioned in outcome 12.

Residents' meetings were convened and there was evidence that issues raised were followed up by management. On the last inspection a consultation process had begun with residents and relatives to facilitate the transition of residents to community accommodation and plans to change the service to an exclusively older persons' service. Inspectors followed up and they were not assured that the consultation process was meaningful and inclusive. For example, photographs of the new accommodation were displayed in the entrance to the centre. However, residents who were due to move to the new accommodation did not have access to this area. No residents or their families had visited the new houses or were involved in selecting furniture or fittings for their new homes.

Many residents living on the ground floor were not supported to exercise choice in so far as such exercise did not interfere with the rights of other residents. For example, inspectors observed that many residents on the ground floor communicated by gestures, shouting and other verbal expressions which initiated negative reactions by other residents in this area. This finding strongly supported the view that residents with communication difficulties were not sufficiently supported and facilitated to communicate freely, having regard to their wellbeing, safety and health and that of other residents in the designated centre. Due to the number of residents confined in one

communal room on the ground floor, combined with their complex care needs and the high noise levels and inadequate staffing; this environment was not adequate, therapeutic, meaningful or restful for residents. Inspectors met some residents on the ground floor who chose to stay in their bedrooms during the day because they did not have access to a peaceful communal space.

Staff were observed by inspectors to make efforts to ensure residents' privacy and dignity were respected by providing discrete assistance and closing bedroom and toilet doors during personal care. However due to overcrowding in the communal room on the ground floor and insufficient staff availability on both floors to care for a number of residents with complex and high care needs, their privacy and dignity needs were not met to a satisfactory standard. For example, inspectors observed that one resident had to undertake a personal activity in the communal area on the ground floor in the presence of 14 other residents and staff. A resident on the first floor who experienced incontinence in the sitting room as staff were not available to provide timely assistance when summoned. Staff told inspectors that the resident concerned was upset by this incident.

Residents could meet with visitors in private if they wished in a sitting room on the first floor, however private space outside residents' bedrooms on the ground floor was limited. Residents were facilitated to practice their religious beliefs.

Judgment:
Non Compliant - Major

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):
No actions were required from the previous inspection.

Findings:
Inspectors found that there was insufficient numbers of staff on duty with the required skills to meet the supervision, personal care and activation needs of residents. In addition staff spoken with also confirmed that they were unable to provide timely assistance to some residents or facilitate activities suitable to residents' interests and capabilities. Inspectors' findings concurred with this information.

Inspectors examined staff rosters and saw that two activity coordinators facilitate residents' activities; one of the two activity coordinators was on leave and was not replaced. Care staff told inspectors that supporting the activity coordinators to facilitate residents' activities was part of their role but they did not have sufficient time to do this as they prioritized personal care for residents. The impact of this finding on residents was that activities scheduled or otherwise on the first floor did not occur and residents with complex needs who required high support did not have their social and emotional needs met. Failure to meet the complex needs of these residents was manifested in high levels of consistent vocalization and self-harm. Although inspectors were told that all vacant staff positions were filled, there was insufficient staff available to provide appropriate supervision for residents. Inspectors observed that one staff member positioned themselves in an area of the corridor to facilitate them with visibility of three communal areas on the first floor. There was up to 16 residents in these three communal areas. Other staff were busy providing personal care to a number of other residents. On a number of occasions on the ground floor, inspectors observed one staff member supervising up to 17 residents who had complex needs and required high support. From speaking with staff, observing residents and staff interactions and the examination of records and rosters, inspectors formed the judgement that staffing arrangements were inadequate to provide timely assistance and to ensure that the social and holistic needs of residents could be effectively met. This was an area of non compliance found on inspection in September 2016 and improvements found on the last inspection in February 2017 had not been sustained.

The provider nominee confirmed that all staff were Garda Vetted. There was evidence that staff were facilitated to attend mandatory and professional development training. Inspectors observed that staff training was scheduled for a number of dates in the months following the inspection.

Clinical nurse managers (CNMs) were on duty on both floors and were rostered over seven days. They assisted other staff with care delivery.

Judgment:
Non Compliant - Major

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:	Blackrock Abbey Nursing Home
Centre ID:	OSV-0000118
Date of inspection:	05/09/2017
Date of response:	09/11/2017

Requirements

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

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

Outcome 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management team did not have effective systems in place to build on progress and support continuous quality improvement. Many of the improvements found on the announced inspection in Feb 2017 were not sustained. Given the history of repeated non compliances found on previous inspections in 2016 in relation to governance and management, safeguarding, staffing and residents rights, privacy and dignity, together with the major non compliances found in relation to staffing and residents' rights,

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

privacy and dignity found on this inspection a judgment of major non compliance was merited for this outcome.

1. 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 Quality Improvement and Resident Safety Programme for Blackrock Abbey is being developed and will be implemented.

Quality Improvement Plans are being developed for the following –
• HIQA Action Plan
• Annual Review of Quality
• Infrastructure/Systems/Equipment
• Hygiene
• Food Safety
• Fire Safety

Regular focused management observational surveys by the PIC to test compliance to policies and ensure best practice occurs will be implemented with effect from 01/11/17. The findings will be documented and reviewed weekly to test for trends. Trends will be analysed and actions agreed to address areas of non-compliance identified will be implemented. The results will be included in the monthly report by the PIC to the management team.

Monthly Huddle groups to review and discuss Schedule 5 policies will be implemented from November 2017. These will be led by the CNM's, on a rotational basis and will include all members of the care team and any residents who are capable of contributing. Attendance will be documented and questionnaires to test attendees understanding of policies will be completed. The results will be included in the monthly report by the PIC to the management team.

The new audit system ViClarity recently introduced to Blackrock Abbey is being implemented on a phased basis. Further training on ViClarity audit system is planned and will be provided. In future details of actions identified as necessary to address areas of non-compliance will be filed with audit results.

An audit file to include the following will be maintained-
• Audit Programme
• Audit Targets
• Audit Tools
• Audit Results
• Action Plans

Monthly management reports to the Management team from the Person In-Charge, Catering & Household Services Manager, Facilities Manager, Social Programmes Manager and Business Manager will be reviewed to ensure that each Manager has

effective systems in place that support continuous quality improvement.

Proposed Timescale: 30/11/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that the staffing resource was not sufficient to ensure the effective delivery of residents' care and quality of life in line with the centre's statement of purpose.

2. 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:
The current rosters (Nursing and Health Care Assistants) on full occupancy provide for a total of fourteen staff on day duty. Activity staff are rostered in addition to Nursing and Health Care Assistant staff. The assignment of staff and allocation of duties is under review to ensure the effective delivery of care in the nursing home.

With the implementation of the HIQA Disability Standards and Regulations we became aware that the needs of a cohort of our residents in the nursing home with an intellectual disability and complex needs would be best met in a designated disability service. In this regard early in 2016 plans to transition some residents with an intellectual disability and complex needs to a specific disability service were developed and extensive consultation took place with the HSE, the families and an Advocacy Service on behalf of the residents concerned. Documentation and minutes are on file to support this engagement. In September 2017 formal agreement was reached with the HSE to commence the transition of residents with intellectual disability and complex needs to community houses where a specific disability service will be provided in line with their assessed needs.

The transition of the residents with an intellectual disability and complex needs to community houses commenced on 25/10/17.

Arrangements have been agreed with the Health Service Executive for other residents with complex needs to transition to the community in January and March 2018.

Discussions are on-going with the Health Service Executive in relation to the transition of one other resident in addition to those already agreed.

Proposed Timescale: 09/03/2018

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Although the frequency of safety checks was indicated when bedrails were in use, there were gaps in the safety checking records.

While there was evidence that staff were ensuring that the periods bedrails and lapbelts were in use was minimized, residents' records did not indicate this practice was consistently implemented.

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

Please state the actions you have taken or are planning to take:
Clinical Nurse Managers are checking records on a daily basis to ensure that checks are being carried out and recorded.

Director of Nursing is checking that there are no gaps in the records.

Audits are being carried out to ensure compliance with national policy.

Proposed Timescale: 09/11/2017

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Inspectors observed that some residents displayed responsive behaviors including self-injurious behaviors in the communal room on the ground floor. In addition, inadequate staffing contributed to the inadequate protection of vulnerable residents.

4. 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:
The current rosters (Nursing and Health Care Assistants) on full occupancy provide for a total of fourteen staff on day duty. Activity staff are rostered in addition to Nursing and Health Care Assistant staff. The assignment of staff and allocation of duties is under review to ensure the effective delivery of care in the nursing home.

With the implementation of the HIQA Disability Standards and Regulations we became aware that the needs of a cohort of our residents in the nursing home with an intellectual disability and complex needs would be best met in a designated disability service. In this regard early in 2016 plans to transition some residents with an intellectual disability and complex needs to a specific disability service were developed and extensive consultation took place with the HSE, the families and an Advocacy Service on behalf of the residents concerned. Documentation and minutes are on file to support this engagement. In September 2017 formal agreement was reached with the HSE to commence the transition of residents with intellectual disability and complex needs to community houses where a specific disability service will be provided in line with their assessed needs.

The transition of the residents with an intellectual disability and complex needs to community houses commenced on 25/10/17.

Arrangements have been agreed with the Health Service Executive for other residents with complex needs to transition to the community in January and March 2018.

Discussions are on-going with the Health Service Executive in relation to the transition of one other resident in addition to those already agreed.

To improve the quality of life for residents, by 30/11/17 residents will be offered a variety of activities in line with their individual interests and preference.

An additional living/dining room with suitable comfortable seating for the benefit of older residents will be provided on the ground floor by 30/11/17.

Proposed Timescale: 09/03/2018

Outcome 08: Health and Safety and Risk Management

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of hazards found on inspection were not appropriately risk assessed with controls implemented where necessary to mitigate potential for occurrence. For example:
- A stairs with an open stairwell had a railing fitted which was not risk assessed to ensure it offered sufficient protection from fall to vulnerable resident and others.
- A balcony located on the first floor had a railing fitted on a low wall around the perimeter was not risk assessed to ensure it offered sufficient protection from fall to vulnerable resident and others.
- Personal protective equipment such as gloves and aprons stored in dispensers on both floors were accessible to vulnerable residents. Access to this equipment was not risk assessed to ensure it did not pose a choking hazard to vulnerable residents or others was not completed.

5. Action Required:
Under Regulation 26(1)(a) you are required to: Ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Risk Assessments of stairs, balcony and personal protective equipment were carried out on 19/10/17 by a Health & Safety Consultant.

The Risk Assessments are now incorporated into the Health & Safety Statement for the centre.

Where control measures have been recommended they are being implemented.

The window in the smoking facility has been trebled in size to facilitate improved supervision. An emergency call bell has been fitted in the smoking shelter.

Proposed Timescale: 31/12/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents who required assistance of a hoist to support their moving and handling needs were not provided with individual slings.

6. 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:
Individual slings are in place for all residents who require assistance of a hoist to support their moving & handling.

Proposed Timescale: 09/11/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The information in residents' personal emergency evacuation plans did not consider their cognitive status and behaviours that required consideration should an emergency evacuation be required.

7. 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:
Personal Emergency Evacuation Plans have been revised to include details of cognitive status and behaviours that require consideration should an emergency evacuation arise.

Proposed Timescale: 09/11/2017

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of abusive behaviour towards a resident by a staff member was not notified to the Health Information and Quality Authority (HIQA) as required.

8. Action Required:
Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

Please state the actions you have taken or are planning to take:
In future allegations of abusive behaviour that are not substantiated will be notified to the Health Information and Quality Authority.

Proposed Timescale: 09/11/2017

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:
Some residents' care plans were not person-centred.

9. 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 review of the quality of care plans has commenced to ensure they are person-centred. This review will also identify staff that would benefit from training in person-centred care planning and the required training will be provided.

The wound care policy has been finalised and implemented.

The ViClarity audit system in place provides for actions to address areas of non-compliance found during the audit process. The actions required to address areas of non-compliance are recorded on the audit system. In future they will be filed with the audit results.

Proposed Timescale: 31/12/2017

Theme:
Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was evidence of improved consultation with residents or their families regarding care plan development and reviews thereafter but this information was inconsistently recorded.

10. 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:
Information arising from the consultation process with residents or their families on care plan development and reviews is now being consistently recorded.

Proposed Timescale: 09/11/2017

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The layout of sitting and dining facilities on the ground floor did not meet the needs of all residents.

There was an absence of suitable comfortable seating provided to meet the needs of older residents in the communal rooms on the ground floor.

A interactive floor mat was not functional.

Equipment such as hoists, assistive chairs and laundry trolleys were stored in annexed areas on corridors on both floors.

11. 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:
An additional living/dining room with suitable comfortable seating for the benefit of older residents will be provided on the ground floor.

The interactive floor mat has been repaired and transferred with the residents transitioning to the community.

One of the annexed areas on the ground floor has been designated for storage of equipment. Alternative storage arrangements for equipment are now in place on the first floor.

One of the annexed areas on the ground floor and both annexed areas on the first floor are now designated as rest areas for residents and will be furnished accordingly.

New covered laundry trollies will be provided.

Proposed Timescale: 30/11/2017

Outcome 16: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents with complex needs on the ground floor did not have adequate facilities provided to meet their social, occupational and recreational needs.

12. Action Required:
Under Regulation 09(2)(a) you are required to: Provide for residents facilities for occupation and recreation.

Please state the actions you have taken or are planning to take:
With the implementation of the HIQA Disability Standards and Regulations we became aware that the needs of a cohort of our residents in the nursing home with an intellectual disability and complex needs would be best met in a designated disability service. In this regard early in 2016 plans to transition some residents with an

intellectual disability and complex needs to a specific disability service were developed and extensive consultation took place with the HSE, the families and an Advocacy Service on behalf of the residents concerned. Documentation and minutes are on file to support this engagement. In September 2017 formal agreement was reached with the HSE to commence the transition of residents with intellectual disability and complex needs to community houses where a specific disability service will be provided in line with their assessed needs.

The transition of the residents with an intellectual disability and complex needs to community houses commenced on 25/10/17.

Arrangements have been agreed with the Health Service Executive for other residents with complex needs to transition to the community in January and March 2018.

Discussions are on-going with the Health Service Executive in relation to the transition of one other resident in addition to those already agreed.

Proposed Timescale: 09/03/2018

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient opportunity for residents to participate in activities in accordance with their interests and capabilities.

13. 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:
A review of attendance at the activities provided indicates that some of the activities are not as popular as in the past. These activities will now be replaced with more regular sessions of activities such as Fit for Life, Relaxation Therapy & Rosary Group which are in greater demand.

A review of Interest Check Lists for all residents is underway. This is to ensure that the interests of the residents is accurately reflected and provided for in the activities programme.

A new timetable for a revised activities programme is being developed. This will clearly indicate the day of the week, time, location and the Activity Instructor responsible for delivering each activity.

To improve the quality of life for residents, residents will be offered a variety of activities in line with their individual interests and preference.

The 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.

Funding was in place and continues to be in place to provide replacement or alternative activities when activity staff are on leave. In future when activity staff are on leave they will be replaced.

Proposed Timescale: 30/11/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Due to overcrowding in the communal room on the ground floor and insufficient staffing residents' privacy and dignity needs were not met to a satisfactory standard.

14. Action Required:
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

Please state the actions you have taken or are planning to take:
The current rosters (Nursing and Health Care Assistants) on full occupancy provide for a total of fourteen staff on day duty. Activity staff are rostered in addition to Nursing and Health Care Assistant staff. The assignment of staff and allocation of duties is under review to ensure the effective delivery of care in the nursing home.

The transition of the residents with an intellectual disability and complex needs to community houses commenced on 25/10/17.

Arrangements have been agreed with the Health Service Executive for other residents with complex needs to transition to the community in January and March 2018.

Discussions are on-going with the Health Service Executive in relation to the transition of one other resident in addition to those already agreed.

An additional living/dining room with suitable comfortable seating for the benefit of older residents will be provided on the ground floor by 30/11/17.

Proposed Timescale: 09/03/2018

Theme:
Person-centred care and support

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

Inspectors were not assured that consultation process regarding their transition to community accommodation was meaningful and inclusive.

15. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
The transition planning process commenced in early 2016 and extensive engagement took place with the HSE, families, residents and their advocates. As the residents concerned have very significant communication difficulties an Independent Advocate from SAGE Advocacy Services has actively participated in the Transition Planning group to represent their interests. The Advocate has also represented the residents where there is no family involvement in their care.

All families were offered a number of opportunities to meet with members of the Transition Planning group. A number of families availed of this opportunity. The Independent Advocate was also in attendance at these meetings. Records of these meetings and the invitations issued to all families to meet are available in the centre.

On the date of the inspection, the 05/09/17, there was no agreement in place with the Health Service Executive in relation to opening of the community houses. Subsequently agreement was reached on 22/09/17 and this facilitated opportunities for residents and families to visit the houses as part of the transition process. This was not possible before reaching agreement as it may have raised expectations that potentially could not be met without having an agreement in place. Following confirmation of agreement, the residents have visited the houses and they will transfer their personal items which will personalise their rooms.

The first residents transitioned to the community houses on 25/10/17 and these residents took their personal items from Blackrock Abbey to their new home to personalise their rooms. In addition, the PIC and staff are working with the residents to select personal bed linen, pictures, towels etc. in addition to those already provided.

Additional photographs of the community houses have also been put on display in the communal area currently used by the residents who will transfer to the community.

Proposed Timescale: 09/11/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents due to transition to community accommodation did not have appropriate access to voluntary groups, community resources and events

16. Action Required:

Under Regulation 09(3)(c)(iv) you are required to: Ensure that each resident has access to voluntary groups, community resources and events.

Please state the actions you have taken or are planning to take:
Following the inspection on 05/09/17 and subsequent agreement dated 22/09/17 with the Health Service Executive on the transition of the residents to the community, a number of meetings were held to explore and agree how best to support the residents through the transition process and establishing the service in the community to meet their individual needs. This was not possible before reaching agreement as it may have raised expectations that potentially could not be met without having an agreement in place.

Proposed Timescale: 09/03/2018

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents with communication difficulties were not supported to communicate freely, having regard to their wellbeing, safety and health and that of other residents in the designated centre.

17. Action Required:
Under Regulation 10(1) you are required to: Ensure that each resident, who has communication difficulties may communicate freely, having regard to his or her wellbeing, safety and health and that of other residents in the designated centre.

Please state the actions you have taken or are planning to take:
Plans have been agreed with the Health Service Executive for residents assessed as suitable, with complex needs, including communication difficulties to transition to three community houses.

The transition of the residents with an intellectual disability and complex needs to community houses commenced on 25/10/17.

Arrangements have been agreed with the Health Service Executive for other residents with complex needs to transition to the community in January and March 2018.

Discussions are on-going with the Health Service Executive in relation to the transition of one other resident in addition to those already agreed.

An additional living/dining room with suitable comfortable seating for the benefit of older residents will be provided on the ground floor by 30/11/17.

The current rosters (Nursing and Health Care Assistants) on full occupancy provide for a total of fourteen staff on day duty. Activity staff are rostered in addition to Nursing and Health Care Assistant staff. The assignment of staff and allocation of duties is under

review to ensure the effective delivery of care in the nursing home.

Proposed Timescale: 09/03/2018

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staffing arrangements were inadequate to provide timely assistance and to ensure that the social and holistic needs of residents could be effectively met. This was an area of non compliance found on inspection in September 2016 and improvements found on the last inspection in February 2017 had not been sustained.

18. 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:
The current rosters (Nursing and Health Care Assistants) on full occupancy provide for a total of fourteen staff on day duty. Activity staff are rostered in addition to Nursing and Health Care Assistant staff. The assignment of staff and allocation of duties is under review to ensure the effective delivery of care in the nursing home.

With the implementation of the HIQA Disability Standards and Regulations we became aware that the needs of a cohort of our residents in the nursing home with an intellectual disability and complex needs would be best met in a designated disability service. In this regard early in 2016 plans to transition some residents with an intellectual disability and complex needs to a specific disability service were developed and extensive consultation took place with the HSE, the families and an Advocacy Service on behalf of the residents concerned. Documentation and minutes are on file to support this engagement. In September 2017 formal agreement was reached with the HSE to commence the transition of residents with intellectual disability and complex needs to community houses where a specific disability service will be provided in line with their assessed needs.

The transition of the residents with an intellectual disability and complex needs to community houses commenced on 25/10/17.

Arrangements have been agreed with the Health Service Executive for other residents with complex needs to transition to the community in January and March 2018.

Discussions are on-going with the Health Service Executive in relation to the transition of one other resident in addition to those already agreed.

A new timetable for a revised activities programme is being developed. This will clearly indicate the day of the week, time, location and the Activity Instructor responsible for delivering each activity.

To improve the quality of life for residents, residents will be offered a variety of activities in line with their individual interests and preference.

The 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.

Funding was in place and continues to be in place to provide replacement or alternative activities when activity staff are on leave. In future when activity staff are on leave they will be replaced.

Proposed Timescale: 09/03/2018