

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Beaumont Residential Care
Centre ID:	OSV-0000198
Centre address:	Woodvale Road, Beaumont, Cork.
Telephone number:	021 429 2195
Email address:	admin@brccork.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Beaumont Residential Care
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	73
Number of vacancies on the date of inspection:	0

About Dementia Care Thematic Inspections

The purpose of regulation in relation to residential care of dependent Older Persons is to safeguard and ensure that the health, wellbeing and quality of life of residents is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer and more fulfilling lives. This provides assurances to the public, relatives and residents that a service meets the requirements of quality standards which are underpinned by regulations.

Thematic inspections were developed to drive quality improvement and focus on a specific aspect of care. The dementia care thematic inspection focuses on the quality of life of people with dementia and monitors the level of compliance with the regulations and standards in relation to residents with dementia. The aim of these inspections is to understand the lived experiences of people with dementia in designated centres and to promote best practice in relation to residents receiving meaningful, individualised, person centred care.

Please note the definition of the following term used in reports:
responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
15 May 2018 10:00	15 May 2018 18:00
16 May 2018 08:00	16 May 2018 18:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Substantially Compliant	Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Non Compliant - Moderate
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Substantially Compliant
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 12: Notification of Incidents		Non Compliant - Moderate

Summary of findings from this inspection

Beaumont Residential Care is a purpose-built residential centre, with accommodation for 73 residents. The centre is located in the suburbs of Cork city and is situated on large, well maintained, landscaped grounds with adequate parking facilities. It is a two storey premises with bedroom accommodation on both floors. The first floor is accessible by two sets of stairs and two lifts.

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. During the inspection, some

required improvements were identified in two additional outcomes and they are included in this inspection report. The purpose of this inspection was to focus on the care and quality of life for residents with dementia living in the centre. Of the 73 residents who were living in the centre on the day of the inspection 40 had a diagnosis of dementia. Ten of these residents were accommodated in a dementia specific unit.

The provider had submitted a completed self assessment on dementia care to the Authority with relevant policies and procedures prior to the inspection. The judgments from the self assessment and inspection findings are set out in the table above.

There were systems in place to support residents with dementia and their representatives to participate in the assessments, care plans and the organisation of the centre. The centre had a stable workforce of long term staff, with low levels of absenteeism. Overall, residents' healthcare and nursing needs were met to a high standard. Residents had good access to medical care and their healthcare needs were met to a good standard. The management of complaints was fully compliant with regulations. Appropriate policies and procedures were in place to protect residents from any form of abuse and residents had access to advocacy services. Inspectors found that staffing arrangements facilitated continuity of care and supported a consistent positive approach to the behaviours and psychological symptoms of dementia (BPSD).

As part of the inspection, the inspector spent a period of time observing staff interactions with residents. A validated observational tool (the quality of interactions schedule, or QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. Observations were recorded in the main sitting room and in the East Wing sitting room. Overall, the inspector observed that staff engaged and interacted meaningfully with residents while providing care.

The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable and homely way. The centre was clean, spacious and decorated to a high standard throughout. All areas were bright and well lit, with lots of natural light. The East Wing, the designated dementia unit, was painted in bright colours with floral murals on the walls. The doors to the bedrooms were all different colours to support residents identify their own bedrooms. There was free access to secure outdoor space from this unit, which contained garden furniture and various shrubbery. While the rest of the centre was clean and bright, the use of contrasting colour that was evident in the East Wing, had not yet extended to this area of the centre.

Residents' records were mostly electronic, including the records created by GPs and allied health/specialist services. Care plans were developed for issues identified on assessment. These were seen to be personalised and provided good guidance on the care to be delivered. Residents had access to general practitioners (GPs) of their choice. Medical notes indicated that residents were reviewed regularly by their respective GPs. Out-of-hours GP services were also available.

Some improvements were required in relation to staff supervision. Where it was identified that increased supervision could enhance the performance of staff, there were times when this was not in place. Improvements were also required in relation to the submission of notifications to HIQA as required by the regulations. Notifications of the unexpected death of a resident, injury of a resident requiring medical treatment, residents that were absenting themselves from the centre without leave, and suspicions or allegations of abuse, were not always submitted. Care plans were developed for residents that smoked to identify the level of supervision required while smoking and the level of access to cigarettes and lighters. The location and design of the smoking room, however, did not facilitate the supervision of residents while they smoked and there were not adequate systems in place to counteract these limitations. Fire drills were conducted frequently, however, there were not adequate records maintained to identify the scenario simulated or if there was any learning from the drill.

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 Quality 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 Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:

Safe care and support

Outstanding requirement(s) from previous inspection(s):

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

Findings:

This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

Residents had access to general practitioners (GPs) of their choice. Medical notes indicated that residents were reviewed regularly by their respective GPs. Out-of-hours GP services were also available. Speech and language therapy and dietetics were provided through a nutritional company and there was usually a timely response following referral. A physiotherapy company visited the centre each week to provide group exercises but also provided one to one assessments for residents, if there was a change in their mobility status. The inspector was informed that residents could not access occupational therapy through the public system and this was also provided through a nutritional supply company. Other services available included palliative care and chiropody.

The inspector focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia. The inspector also reviewed specific aspects of care such as wound care and restrictive practices in relation to other residents. A sample of residents' records, some of whom had been transferred to hospital from the centre, demonstrated that appropriate information about their health, medications and their specific communication needs were shared with the admitting hospital.

A pre-admission assessment was usually carried out prior to admission to the centre to determine if the centre could adequately meet the needs of the resident. The person in charge would either go to assess the resident in their home, hospital or another centre or the resident may visit the centre prior to admission.

Residents' records were mostly electronic, including the records created by GPs and allied health/specialist services that visited the centre. Care plans were developed for issues identified on assessment. These were seen to be personalised and provided good

guidance on the care to be delivered

There were written policies and procedures in place for end-of-life care. Staff provided end of life care to residents with the support of their GP and the community palliative care team. The inspector reviewed the record of a resident that was identified as being at end of life and was satisfied that end-of-life care was provided to a good standard. Records indicated the involvement of the family and the support of the palliative care team.

Religious preferences were documented and there was evidence that they were facilitated. Most residents were catholic and a priest visited the centre each week to celebrate mass. The needs of other denominations were respected and supported. A spiritual counsellor visited residents that expressed a preference for support from a service that was non-denominational. All of the bedrooms were single rooms, so the option of a single room was always available. Family and friends were facilitated to remain with the resident and there were adequate facilities for relatives to remain overnight.

There were policies and procedures to guide practice in relation to the management of nutrition. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were weighed regularly and were assessed for the risk of malnutrition on admission and at regular intervals thereafter. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served. Residents that were identified as having unintentional weight loss were assessed by a dietician and advice to increase calorific intake had been appropriately communicated to catering staff.

Most residents had breakfasts in their bedrooms, which was served at approximately 08:15hrs but had their lunch and tea in the dining room. Fluids were available throughout the day and tea/coffee and snacks were served between meals and in the evening. On the day of the inspection there were adequate numbers of staff on duty to assist residents with their meals. Residents requiring assistance were assisted by staff in a respectful and dignified manner.

The centre had operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. There were processes in place for the handling of medicines including controlled drugs, which were safe and in accordance with current guidelines and legislation. Medication administration practices observed by the inspector were in compliance with relevant professional guidance. A review of a sample of medication prescription and administration charts indicated that practices employed were in compliance with the centre's policies on medication management. Medication management practices were audited, including an audit of medication errors to identify ways to minimise the risk of further errors. There were appropriate procedures in place for the management of unused or out-of-date medication. Medication requiring refrigeration were stored appropriately and the fridge temperature was monitored and recorded.

This outcome was judged to be substantially compliant in the self assessment, and the inspector judged it as compliant.

Judgment:

Compliant

Outcome 02: Safeguarding and Safety

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 an up-to-date policy in place that addressed prevention, detection, reporting and investigating allegations or suspicions of abuse. A sample of staff spoken with by the inspector were knowledgeable of what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about a colleague's behaviour.

Where there were suspicions or allegations of abuse, these were reported by staff, recorded and investigated. Where the outcome of the investigation indicated that staff required further training and supervision, this was put in place, however, some improvements were required. This is discussed in more detail under Outcome 6, Staffing. All residents spoken with said they felt safe and secure in the centre, and felt that staff were supportive. Relatives of residents spoke highly of the care provided by the staff and their caring attitude.

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. The inspector reviewed incident reports in relation to resident's behaviour and records confirmed the information given to the inspector that there were no recent significant behavioural related incidents. Records indicated that restraint in the form of bedrails was used following a risk assessment. The person in charge was requested to review the restraint register. According to the register, there were four residents that had bedrails in place that were considered restraint, while 21 residents had bedrails in place for "support". This differentiation is not in compliance with national policy. Similar to the finding of the last inspection, contemporaneous records were not maintained of safety checks while bedrails were in place.

There were adequate records in place on the management of residents finances, which included signed receipts for all transactions.

This outcome was judged to be compliant in the self assessment, however, the inspector judged it as non-compliant - moderate.

Judgment:

Non Compliant - Moderate

Outcome 03: Residents' Rights, Dignity and Consultation

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 confirmed that their religious and civil rights were supported. The preferences of all religious denominations were respected and facilitated. Religious ceremonies were celebrated in the centre that included a weekly mass for Catholic residents, usually on Fridays. Residents were facilitated to vote in local and national elections and the returning officer was present in the centre on one of the days of the inspection to facilitate residents to vote in the referendum. Residents had access to the services of an advocate.

Residents meetings were held in the centre approximately every two months. Records of residents meetings were reviewed and issues discussed included privacy and dignity, nutrition, activities and the environment. There was an action plan associated with each meeting identifying how issues raised would be addressed.

The inspector observed staff interacting with residents in an appropriate and respectful manner. Residents chose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup.

Residents had access to a number of private areas and rooms whereby they could meet with family and friends in private, or they could meet with them in their bedrooms. All of the bedrooms were single rooms and these were seen to be personalised and were adequate in size for residents to have a comfortable chair, bedside locker, chest of drawers and wardrobe.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents. A validated observational tool (the quality of interactions schedule, or QUIS) was used to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An overview of these observation periods is detailed below.

Observations were recorded in the main sitting room and in the East Wing sitting room. The total observation period was 90 minutes, which comprised three 30 minute periods. For rating purposes, there were 18 five minute observation periods. Twelve scores of +2 were given predominantly when staff were seen to facilitate activities and to sit and chat with residents. Four scores of +1 were given when staff were seen to assist residents, for example to walk to the dining room with minimal interaction. Two scores of 0 were given when residents were alone in the sitting room.

There was an activities coordinator available in the centre for three days each week. The activities coordinator facilitated group activities such as sing-alongs, relaxation therapy, quizzes, and skittles. She also spent one-to-one time with residents that chose not to participate in group activities. Activities were also provided by external providers on other days of the week. An organisation that specialised in providing activities to residents of nursing homes visited the centre for two days each week. Another organisation visited for one day each week to lead groups in physical exercises but also provided one-to-one assessments for some residents. An art therapist visited the centre on one day a week.

Residents in the East Wing were seen to assist with various chores, such as setting the table, wash up after meals and to sweep the floor. Residents were seen to be wearing glasses and hearing aids, to meet their communication needs.

This outcome was judged to be compliant in the self assessment, and the inspector judged it as compliant.

Judgment:
Compliant

Outcome 04: Complaints procedures

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 system in place to ensure that the complaints of residents or their representative were listened to and acted upon. There was a complaints policy that identified the person responsible for managing complaints and also included an appeals process. The complaints procedure was on prominent display in the centre, and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of management including the person in charge and the clinical nurse manager. It was apparent to the inspector that residents would find staff easy to approach with any

concerns or complaints.

Inspectors viewed the complaints log that contained details of complaints, the investigation of each complaint, the outcome of the investigation and whether or not the complainant was satisfied with the outcome of the complaint.

This outcome was judged to be compliant in the self assessment, and the inspector judged it as compliant.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

Outstanding requirement(s) from previous inspection(s):

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

Findings:

The inspector observed staff providing care in a respectful and caring manner. Residents appeared to be familiar with staff. An actual and planned roster was maintained in the centre, with any changes clearly indicated. The person in charge was supported in her role by a clinical nurse manager. There was a regular pattern of rostered care staff.

The staffing complement included staff nurses, healthcare assistants, catering staff, housekeeping staff, administrative staff and maintenance. Based on a review of the roster and discussions with residents and staff, there were adequate numbers and skill mix of staff to meet the needs of residents.

There was a varied programme of training for staff. In addition to mandatory training the training programme included training on issues such as nutrition, end-of-life care, cardiopulmonary resuscitation (CPR), wound care and medication management. The person in charge was requested to review the provision of training in areas such as dementia care, responsive behaviour and safeguarding to ensure that it was an accredited program.

There was a system of staff appraisal. In instances where it was identified that some staff would benefit from a period of increased supervision, this was put in place. However, there were times when the level of supervision was not adequate, such as when two staff undergoing a period of increased supervision worked together with inadequate supervision arrangements.

The inspector reviewed a sample of staff files and found that all of the requirements of Schedule 2 of the regulations were met in the sample of files viewed.

This outcome was judged to be substantially compliant in the self-assessment and the inspector judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

Beaumont Residential Care is a purpose-built residential centre, with accommodation for 73 residents. The centre is located in the suburbs of Cork city and is situated on large, well maintained, landscaped grounds with adequate parking facilities. It is a two storey premises with bedroom accommodation on both floors. The first floor is accessible by two sets of stairs and two lifts.

On the days of inspection, the centre was bright, clean, spacious and decorated to a high standard throughout. Resident accommodation comprises 73 single bedrooms, all of which are en suite with shower, toilet and wash-hand basin. The centre is divided into three sections; the main ground floor wing has bedroom accommodates for 19 residents; the East Wing is the designated dementia unit and accommodates 10 residents; and the first floor has bedroom accommodation for 44 residents.

All bedrooms were spacious and were seen to be personalised with residents' individual property and possessions. There was adequate space in the bedrooms for furniture such as a bed, a chair and bedside locker. The rooms also had enough space for equipment such as hoists to be used, with sufficient space to access the beds from either side.

The East Wing, the designated dementia unit, was painted in bright colours with floral murals on the walls. The doors to the bedrooms were all different colours to support residents identify their own bedrooms. Communal space in the East Wing comprised a sitting room, a kitchen/dining room and there was also seated areas along the corridor. There were rummage boxes along the corridors and there were various memorabilia, such as a record player, a typewriter and an old style telephone. There was free access to secure outdoor space from this unit, which contained garden furniture and various shrubbery.

Communal areas in the main wing on the ground floor included a reception area, a sitting room, a television lounge, a dining room, a reading room and a visitors' room. There was a secure garden with shrubs and flower beds that was maintained with

assistance of one of the residents. Communal space on the first floor comprises one small sitting room. Residents on the first floor were seen to use the lift and many of these residents spent daytime hours in the communal rooms downstairs. The use of contrasting colour that was evident in the East Wing, had not yet extended to the main part of the centre.

There were adequate sanitary, laundry and sluicing facilities. Access to rooms such as the treatment room, sluice rooms, laundry, cleaners' room were all secure on the day of inspection. Windows have restrictors applied to prevent them from opening fully.

This outcome was judged to be compliant in the self assessment, and the inspector judged it as compliant.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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:

At the previous inspection it was identified that there were inadequate supervision arrangements in place for residents that smoked. On this inspection it was found that all residents were assessed for their ability to smoke independently. A care plan was developed for residents that smoked, which identified the level of supervision required and level of access to cigarettes and lighters. In instances where residents were not complying with the centre's smoking policy, additional measures were put in place. While these improvements are noted, no changes were made to the smoking room. The smoking room was located at the end of a corridor on the first floor and was remote from the rest of the centre. There was no viewing panel to support the observation of residents while in the room. The inspector was not satisfied that adequate supervision arrangements were in place for residents that smoked.

Records and discussions with staff indicated that there were frequent fire drills. There were, however, inadequate records maintained identifying the scenario simulated in the drill and whether or not the scenario simulated the evacuation of a whole compartment. Additionally, it was not recorded how long it took staff to simulate the evacuation of residents, whether there were areas for improvements or if there were improvements noted from the previous fire drill.

Judgment:

Non Compliant - Moderate

Outcome 12: Notification of Incidents

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:

A number of notifications were not submitted to HIQA within the required timeframe as required. For example:

- not all incidents where resident left the centre when it was determined that it was unsafe for that resident to do so, were notified
- not all incidents of injury requiring medical attention were notified
- not all suspicions or allegations of abuse were notified
- not all unexpected deaths were notified.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
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 report¹

Centre name:	Beaumont Residential Care
Centre ID:	OSV-0000198
Date of inspection:	15/05/2018 and 16/05/2018
Date of response:	15/06/2018

Requirements

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

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

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Records indicated that restraint in the form of bedrails was used following a risk assessment. The person in charge was requested to review the restraint register as according to the register there were only four residents that had bedrails in place as a form of restraint while 21 residents had bedrails in place for "support". This differentiation is not in compliance with national policy. Similar to the finding of the last inspection, contemporaneous records were not maintained of safety checks while

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

bedrails were in place.

1. 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:

A record of safety checks being carried out will be recorded contemporaneously. To facilitate this, a record keeping mechanism will be implemented and staff will be trained in its use.

Proposed Timescale: 30/08/2018

Outcome 05: Suitable Staffing

Theme:

Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

In instances where it was identified that some staff would benefit from a period of increased supervision, this was put in place. However, there were times when the level of supervision was not adequate, such as when two staff undergoing a period of increased supervision worked together with inadequate supervision arrangements.

2. Action Required:

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

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

All health care staff have regular formal supervision, and where it is identified that staff might benefit from increased supervision/mentoring, this is usually prioritised. In this instance it seems that there was a communication gap (at this time we had recruited several new staff nurses).

All Staff Nurses are now regularly made aware by senior clinical staff of staff members in need of increased supervision. This will now be documented in the personnel files of the particular staff members along with an appropriate time frame of supervision. An evaluation of the mentoring and supervision will then be made by the DON or CNM2, documented and actioned.

Proposed Timescale: 15/06/2018

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

The smoking room was located at the end of a corridor on the first floor and was remote from the rest of the centre. There was no viewing panel to support the observation of residents while in the room. The inspector was not satisfied that adequate supervision arrangements were in place for residents that smoked.

3. 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:

As previously communicated to HIQA, we have a no smoking policy in operation for a number of years and, of our 73 residents, just four are now considered "smokers". If any resident does not comply with our smoking policy, measures will be taken to ensure that all residents are protected from the risks associated with smoking.

All residents that are considered responsible and not considered a significant risk to themselves or others will continue to be monitored/risk assessed. For health & safety reasons only limited supervision can be undertaken while residents are in our smoking room, i.e., intermittent checks. We accept our current smoking room is not ideal and are currently investigating if it is feasible to install a viewing panel and CCTV camera to improve visibility / monitoring from outside.

We will of course continue to closely monitor residents who smoke and if, in the opinion of senior management (Provider, PIC, CNM2), a particular resident is no longer deemed "safe" to smoke or whose smoking habit cannot be managed/controlled within our infrastructure, we shall request that the resident stops smoking altogether (with supports) or, as a last resort issue notice to terminate the Contract for Care as has happened with the above resident.

Proposed Timescale: 30/08/2018

Theme:

Safe care and support

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

Records and discussions with staff indicated that there were frequent fire drills. There were, however, inadequate records maintained identifying the scenario simulated in the drill and whether or not the scenario simulated the evacuation of a whole compartment. Additionally, it was not recorded how long it took staff to simulate the evacuation of residents, whether there were areas for improvements or if there were improvements noted from the previous fire drill.

4. Action Required:

Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

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

Every employee receives detailed training in fire safety practices (Fire escape routes, location & use of fire fire-fighting equipment, evacuation of ambulant and non-ambulant residents using ski-sheets, simulating evacuation of a compartment etc.) at least once a year. Training sessions are scheduled according to usual shift patterns of individual staff members (for day staff usually between midday and 7pm, and for night staff between 8pm and midnight).

In addition, we will now record the exact time of the drill and the time it takes to evacuate a compartment. We have introduced a new Fire Drill Report Sheet which includes the following details: Date, Time training started & finished, Time evacuation started & finished, which compartment was evacuated, How many residents were evacuated, How many of those are ambulant/non-ambulant as well as an evaluation of all topics covered.

Proposed Timescale: 15/06/2018

Outcome 12: Notification of Incidents

Theme:

Effective care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

A number of notifications were not submitted to HIQA within the required timeframe as required. For example:

- not all incidents where resident left the centre when it was determined that it was unsafe for that resident to do so, were notified
- not all incidents of injury requiring medical attention were notified
- not all suspicions or allegations of abuse were notified
- not all unexpected deaths were notified.

5. 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:

- Reporting obligations in relation to residents leaving the centre when determined it was unsafe for them to do so, required some clarification. Previously we understood that this involved residents leaving the grounds of the home. We now understand that a resident, who has been identified as being unsafe to leave the building and who exits

any door of the building, has technically left the centre, regardless whether or not the resident has immediately been returned to the building. This will now be communicated to all staff, and administration personnel will inform the DON/CNM2 immediately of any such incident. Notification will then be submitted within the required three working days.

- The home operates a zero tolerance approach to all types of abuse and staff are actively encouraged to report suspicions with the appropriate support if needed. All suspicions /complaints are initially recorded as such in our electronic record management system, and a complaints-handling workflow has been developed to clarify which policies to investigate under. An investigation is carried out under the Prevention of Abuse to Residents Policy (SOP 32) if this is then deemed appropriate. Where the investigation fails to uphold the allegation/complaint, the report previously had not been notified. However if internal investigations found the allegation to be founded notification had always been made. Notification of all allegations/suspicions will now be submitted, whether founded or unfounded.
- All unexpected deaths of residents have routinely been notified to HIOA. However, the incident referred to by the Inspector involved the death of a resident in hospital some days after transfer from the nursing home. It was assumed notification would be made to the appropriate authorities by the hospital itself. However, we now understand the nursing home is also expected to notify HIOA. Nursing staff have been informed.

Proposed Timescale: 15/06/2018