## Compliance Monitoring Inspection report

**Designated Centres under Health Act 2007, as amended**

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Consolation Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000079</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Arden Road, Tullamore, Offaly.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>057 932 1320</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:rosmycunningham@yahoo.ie">rosmycunningham@yahoo.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>Our Lady of Consolation Nursing Home Limited</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Rosmy Cunningham</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sonia McCague</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>25</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>0</td>
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</table>
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).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tbody>
<tr>
<td>13 February 2017 10:50</td>
<td>13 February 2017 20:30</td>
</tr>
<tr>
<td>14 February 2017 08:00</td>
<td>14 February 2017 13:30</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Statement of Purpose</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Governance and Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Information for residents</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 04: Suitable Person in Charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Documentation to be kept at a designated centre</td>
<td>Non Compliant - Major</td>
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<tr>
<td>Outcome 06: Absence of the Person in charge</td>
<td>Compliant</td>
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<tr>
<td>Outcome 07: Safeguarding and Safety</td>
<td>Compliant</td>
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<tr>
<td>Outcome 08: Health and Safety and Risk Management</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 09: Medication Management</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 10: Notification of Incidents</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 11: Health and Social Care Needs</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 12: Safe and Suitable Premises</td>
<td>Non Compliant - Moderate</td>
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<tr>
<td>Outcome 13: Complaints procedures</td>
<td>Compliant</td>
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<tr>
<td>Outcome 14: End of Life Care</td>
<td>Compliant</td>
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<tr>
<td>Outcome 15: Food and Nutrition</td>
<td>Compliant</td>
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<tr>
<td>Outcome 16: Residents’ Rights, Dignity and Consultation</td>
<td>Compliant</td>
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<tr>
<td>Outcome 17: Residents’ clothing and personal property and possessions</td>
<td>Compliant</td>
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<tr>
<td>Outcome 18: Suitable Staffing</td>
<td>Non Compliant - Moderate</td>
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Summary of findings from this inspection

This report sets out the findings of a two-day inspection, the purpose of which is to inform a decision for the renewal of the centre's registration.

During the course of the inspection, the inspector met with residents and staff, the person in charge who is also the provider nominee. The views of residents and staff were listened to, practices were observed and documentation was reviewed. Surveys
completed by residents and/or their relatives or representatives were also reviewed.

Overall, the inspector found that care was delivered to a high standard by staff who knew the residents well and discharged their duties in a respectful and dignified way.

The management and staff of the centre were striving to improve residents’ outcomes. A person-centred approach to care was noted. Residents appeared well cared for and expressed satisfaction with the care they received in the centre and confirmed that they had autonomy and freedom of choice. Residents spoke positively about the staff who cared for them.

Reasonable systems and appropriate measures were in place to manage and govern this centre. The person in charge and staff team responsible for the governance, operational management and administration of services and resources demonstrated sufficient knowledge and were determined to meet regulatory requirements.

Following previous inspections, the registered provider was required to submit a costed, time bound plan to the Health Information and Quality Authority (HIQA) that addressed non compliances related to the layout and design of the premises. However, this was not provided or completed to date and remained outstanding.

Many actions required following the last inspection in July 2016 had been addressed. However, non-compliance with the regulations related to the premises, risk management, governance, staff training, staff recruitment and files. Three rostered staff employed after 29 April 2016 were not Garda vetted. The provider and person in charge were asked to address this immediately. The person in charge also confirmed in writing that all staff had completed Garda vetting.

Actions required in relation to these matters are discussed in the body of the report and are outlined in the Action Plan at the end of the report for response.
Outcome 01: Statement of Purpose
There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Governance, Leadership and Management

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

Findings:
The statement of purpose detailed the aims, objectives and ethos of the centre. It outlined the facilities and services provided for residents and contained information in relation to the matters listed in schedule 1 of the regulations.

The provider and person in charge understood that it was necessary to keep the document under review and notify the Chief Inspector in writing before changes could be made which would affect the purpose and function of the centre.

Details to include the specified fee and staff compliment to include those working in the centre as maintenance and administration was to be included and submitted in a revised document.

Judgment:
Substantially Compliant

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

Theme:
Governance, Leadership and Management

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

**Findings:**
Improvement was found in relation to the governance and management arrangements. However, further improvement was needed in a timely manner to address the administration requirements and provision of schedule 2 records for all persons working in the designated centre. The provider was also required to submit a timebound costed plan to address the deficiencies of the design and layout of the premises.

A copy of the final as-built or as-is floor plan was required to reflect the facilities available as the one submitted did not specify or make clear the number of bathrooms and toilet facilities located along each corridor. The floor plan submitted with the application did not include all resident facilities.

There were sufficient arrangements and resources in place to ensure the effective delivery of care as described in the statement of purpose. There was a clearly defined management structure with explicit lines of authority and accountability, and the management team's roles and responsibilities for the provision of care are unambiguous.

Staff, residents and family members were familiar with the staffing and management arrangements. Staff, residents and relatives were complimentary of the management and staff team, telling the inspector that staff were responsive, friendly, approachable and receptive to new ideas.

A comprehensive auditing and management system was in place and developed since the previous inspection to capture statistical information in relation to quality outcomes, operational matters, resident outcomes and staffing arrangements.

Monthly and quarterly audits were carried out that analysed incidents, accidents, complaints, medicine management, skin integrity, care plans, the use of restraint, nutritional risk and dependency levels. This information was available for inspection. A low level of incidents, accidents and complaints was reported.

An annual review of the quality and safety of care delivered to residents for 2016 was completed to address the previous finding and inform the service plan for 2017.

Conversations with residents during the inspection and satisfaction surveys completed by or on behalf of residents were positive in respect to the provision of the care, the facilities and the services provided. A high level of satisfaction with the service was reported in the 14 questionnaires completed for this inspection.

There was much evidence of consultation with residents and their representatives on a daily basis and in a formal resident and relative forum held quarterly. Other opportunities for consultation was afforded when staff were engaged in reviewing and assessing the changing needs of residents and care planning process, during social and recreational activities and during discussions at meal times.

**Judgment:**
Outcome 03: Information for residents
A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:
Governance, Leadership and Management

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

Findings:
A guide to the centre for residents included a summary of the centre's services and facilities, the terms and conditions of residence, the complaints procedure and visiting arrangements for residents.

The inspector reviewed a sample of residents' contracts of care, which were found to set out the services provided and the agreed fees charged to residents. Following the amendment to the Regulations in June 2016 the PIC agreed to amend the contract of care template to include terms relating to the bedroom to be provided and the number of occupants to be accommodated within the bedroom provided.

Judgment:
Substantially Compliant

Outcome 04: Suitable Person in Charge
The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Governance, Leadership and Management

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

Findings:
There was no change in the person in charge of the centre since the last inspection.

The person in charge is also the provider representative. She is a registered general nurse, has experience of working with older persons in the previous three years and works full time in the centre. The person in charge is committed to her own professional development and had completed a degree in healthcare management since the previous
During the inspection she demonstrated that she had knowledge of the regulations and standards pertaining to the care and welfare of residents in the centre.

She is supported in her role by the nursing, care, maintenance, kitchen and housekeeping staff, who report directly to her and she in turn reports to the provider.

The inspector was satisfied that the centre was being well managed by a suitably qualified and experienced nurse who has authority and is accountable and responsible for the provision of the service.

The person in charge and the staff team facilitated the inspection process by providing documents available and had good knowledge of residents' care and conditions.

Staff confirmed that good communications exist within the staff and management team and residents highlighted the positive interactions and support provided by the entire team. Minutes of staff meetings were recorded and available.

**Judgment:**
Compliant

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

**Theme:**
Governance, Leadership and Management

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

**Findings:**
Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People), Regulations 2013 (as amended) were available and a sample of records was reviewed by the inspector. These included records relating to fire safety, staff recruitment and residents' care, as well as the centre's statement of purpose, directory of residents, policies and procedures and medical records. The safe storage of records was maintained, however, improvement was required to ensure completeness as follows:
- a record of assessment or treatment to residents by practitioners attending residents in a private or public capacity should be maintained and recorded on a separate document pertaining to individual residents
- the logging of maintenance requests required improvement to ensure the responsible person is notified to ensure a timely response.

A sample of staff files were reviewed against the requirements of schedule 2. The inspector found gaps and an absence of the required records such as a record of a vetting disclosure in accordance with the National Vetting Bureau for 3 staff members recruited after 29 April 2016. This was also a finding on the previous inspection. In addition there was an absence of two written references, including a reference from a person’s most recent employer. Furthermore, a contract or record that detailed the dates on which staff commenced or ceased employment and the position they held was not available for some staff. The person in charge, as provider nominee, gave verbal and written assurances that any person without Garda vetting would not be working or rostered to work in the centre. She later confirmed in writing that all staff had completed Garda vetting.

A directory of residents was available and maintained in the centre, as required.

A register for visitors to record entry and exit to the centre was available in the entrance hall, however, a record of all visitors to the centre on the first day of the inspection was not completed or maintained.

The centre’s insurance cover was current and confirmed in a document made available for inspection.

The inspector also reviewed operating policies and procedures for the centre, as required by Schedule 5 of the regulations. All policies listed in Schedule 5 were available to staff, were recently revised and being implemented in practice. Policies had been subject to a review since the previous inspection. The person in charge was to review the details in each policy to ensure they could be implemented in practice, as discussed in outcome 8.

**Judgment:**
Non Compliant - Major

**Outcome 06: Absence of the Person in charge**

The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Governance, Leadership and Management

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
The person in charge as the provider representative was aware of the responsibility to notify the Chief Inspector of her proposed absence from the designated centre in accordance with the regulations.

Arrangements were in place for the management of the designated centre during short term absences. A nurse with experience of nursing older persons was in place to deputise when the person in charge was on leave for short periods.

Judgment:
Compliant

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

Theme:
Safe care and support

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

Findings:
Measures were in place to protect residents from being harmed or suffering abuse.

There was a policy which provided guidance for staff to identify and manage incidents of harm or elder abuse. This included information on the various types of abuse, assessment, reporting and investigation of incidences.

The training records identified that staff had opportunities to participate in training in the identification and protection of residents from abuse. Staff spoken with were fully knowledgeable regarding the signs of abuse, reporting procedures and what to do in the event of a disclosure about actual, alleged, or suspected abuse. There were no incidents or allegation of abuse reported.

Much emphasis was placed on residents’ safety. Measures were in place to ensure that residents felt safe while at the same time had opportunities for maintaining independence and freedom of movement in a supported environment. All parts of the centre or communal areas were accessible to residents. A lack of control over visitors entering and exiting the building at the main entrance doors was found during the inspection and discussed with the management team to highlight the uncontrolled risks that were not sufficiently assessed. As a result, a change in the lock to the main door was applied prior to the completion of this inspection by way of a controllable measure and is discussed further in outcome 8.
The inspector saw that there were facilities in place to assist residents to promote and retain their independence and mobility. For example, call-bell facilities, mobility aids, hand and grab-rails in communal and circulating areas for use by residents.

During conversations with the inspector, residents confirmed that they felt safe in the centre due to the measures in place, such as the support, supervision and care provided by the staff team.

Safe systems and arrangements were in place for safeguarding resident's finances and property. Procedures were in place for carrying out and documenting transactions. In the sample reviewed, the signatories of those involved were maintained and records for any transactions or receipts were kept. The balance checked was correct.

The inspector found that the centre aimed to promote a restraint free environment in line with the national guidance document and centre’s policy. A reduction in the use of bedrails was noted since the previous inspection. The centre’s policy and practice found reflected the national guidance document available to guide restraint usage. A low rate of restraint and/or bedrail use by residents was reported and seen. Restraint risk assessments had been completed and records of decisions regarding the use of bedrails were available to show the decision was made in consultation with the resident or representative and clinical team. Decisions were also reflected in the resident's care records and the subject to regular review. A restraint register was maintained and audited on a weekly basis by the nurses.

The inspector was informed of various types of alternative equipment available and tried prior to the use of bedrails such as low low beds and bedside floor mats. This formed part of the assessment and decisions recorded.

A policy for the management of challenging behaviours was available which provided guidance for staff. Due to their individuality, some residents displayed responsive behaviours that challenged them or those supporting them. During the inspection, the inspector saw staff approach residents in a sensitive and appropriate manner, and the residents responded positively to techniques used and activities provided by staff.

Support from the community mental health team was available and noted to have been facilitated for residents in the records reviewed.

**Judgment:**
Compliant

**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):**
No actions were required from the previous inspection.
**Findings:**
The centre had comprehensive policies and procedures relating to health and safety that included a risk management policy to include items set out in Regulation 26 (1).

Infection control procedures with supporting protocols were also available and implemented in practice.

There were emergency policies and procedures in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.

A risk register with identified hazards and risks that were assessed and rated with applied control measures was maintained and arrangements were in place for investigating and learning from reviews. A recently developed system of quality audits against the standards were completed and followed up with a corrective action report (CAR) were necessary.

Reasonable measures were in place to promote resident safety, and prevent accidents to persons in the centre and on the grounds. However, the inspector found that the provider or person in charge did not have sufficient control over the entry and exit of visitors as many had a key that enabled them unlimited and uncontrolled entry to the centre at any time. This arrangement was discussed with the provider representatives, person in charge and deputy who acknowledged the risk to residents and staff, which resulted in action taken prior to the completion of the inspection to mitigate the identified risk. Further assessment and consideration was to be given to the control of entry and exit.

The management and staff team had completed a review of incidents and accidents involving residents to identify the key cause or likely factors in order to inform control measures put in place. A low number and frequency of incidents involving residents was reported and recorded. There were no serious injuries since the last inspection.

Satisfactory arrangements, consistent with the national guidelines and standards for the prevention and control of healthcare associated infections, were in place. Staff had access to hand washing facilities in rooms and hand sanitisers along corridors. Staff were seen using these hand washing facilities or sanitisers between resident contacts. The standard of cleanliness throughout the centre was good.

Suitable arrangements were in place in relation to servicing of equipment and promoting fire safety. The fire alarm system was serviced on a quarterly basis and fire safety equipment was serviced on an annual basis.

Fire safety and response equipment such as smoke detectors, fire extinguishers and fire blankets was provided. However, emergency evacuation equipment such as ski sheets or pads were not available and bedroom door widths did not facilitate the removal of a bed. The recently implemented emergency fire policy included the provision and use of ski sheets in accordance with a personal emergency evacuation plan (PEEP) for each resident. However, these arrangements were not available, in place or recorded. Some
staff told the inspector they would use the resident's bed sheet to evacuate, however, the inspector was not assured that this would be safe or appropriate for vulnerable residents. The person in charge and staff told the inspector that the fire safety officer was due to visit the centre the following day and all matters raised would be discussed for address accordingly.

Fire exits were identifiable by obvious signage and exits were unobstructed to enable means of escape. Fire procedures were prominently displayed throughout the building. A daily fire alarm test was carried out with checks of fire doors and escape routes completed regularly. Staff were trained in fire safety and those who spoke with the inspector confirmed this.

Staff interviewed and records reviewed confirmed simulated fire drills had occurred. However, the provision of fire drills to residents and staff, and the recording practices required further improvement to ensure a drill simulating evening and night time conditions was practiced that identified those involved, the duration, successes or failures and equipment available or used.

**Judgment:**
Non Compliant - Moderate

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**Outcome 09: Medication Management**

*Each resident is protected by the designated centre’s policies and procedures for medication management.*

**Theme:**
Safe care and support

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

**Findings:**
Residents were protected by safe medication management policies and practices in place.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. The processes in place for the handling of medicines, including controlled drugs, were safe and in accordance with current guidelines and legislation.

Nursing staff were knowledgeable regarding residents use of medicines and demonstrated safe practices in medication administration and management. The inspector observed nurses consulting with residents before, during and after the administration of medicines and performing good hand hygiene. Medication to be given as and when required (PRN) stated the maximum dose that could safely be administered in a 24 hour period to address the previous finding.
Systems were in place for weekly ordering, supply and dispensing methods. There were appropriate procedures for the handling, checking, return and disposal of medicines. The inspector saw that controlled drugs stock levels were recorded at the beginning and end of each shift in a register in keeping with legislative requirements.

A system was in place for reviewing and monitoring safe medication management practices. An arrangement for the review of prescribed medicines by the resident’s GP and nursing staff on a regular basis was in place, and records were available to demonstrate this arrangement was implemented in practice. Some residents had retained the services of the Pharmacist used prior to admission, while others accessed the pharmacy used by the centre. Residents and staff were satisfied with the arrangements in place.

**Judgment:**
Compliant

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**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:**
A record of all incidents occurring in the designated centre was maintained. However, the most recent quarterly report submitted was incomplete in parts and quarterly notifications for the second and third quarter of 2016 had not been notified to the Chief Inspector, as prescribed in the regulations.

In addition, a nil return was not submitted in 2016.

**Judgment:**
Substantially Compliant

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

Findings:
The inspector was satisfied that overall, there were arrangements in place to meet the health and nursing needs of residents.

Improvement was noted in the care planning documentation to ensure that residents, or their relatives as appropriate, were involved in the development or review of their care plans. Named staff members had responsibility to review and update the care plans accordingly.

Care plans were updated routinely or on a four monthly basis. Residents and relatives told the inspector they were involved in the development or review of their care plan.

Regular assessments were completed to inform care plans. In a sample of care plans reviewed the inspector found that they reflected the necessary interventions required and recommended by professionals or those carrying out assessments.

Residents had access to general practitioners (GPs) of their choice and out of hours medical cover was provided. Evidence of access to allied health professionals was found with documented visits, assessments and recommendations by dieticians, speech and language therapists, physiotherapists and occupational therapists. A full range of other services were available on request including chiropody, optical and dental services. Residents also had access to the mental health of later life services, with onsite visits from psychiatry of later life team.

Judgment:
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 premises takes account of the residents’ needs and plans to achieve all the requirements of Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and subsequent amendment.

The centre is registered for a maximum capacity of 25 residents. All accommodation is on the ground floor. The centre comprises of 11 single and seven twin bedrooms, each with a wash hand basin facility. The bedrooms are located along two corridors that include three bath/shower rooms and five independent toilets. The kitchen, dining and sitting room areas are centrally located. A sluice room is located on each of the two corridors where residents’ bedrooms are located.

While there is a laundry room within the premises, the inspector was told that the machines were not operational and that laundering of bed linen, towels and personal clothes of residents is outsourced and not maintained onsite. Some provision to hand wash small items was described.

The sitting room, visitor's room, seated area in the front hall and the dining room were decorated with colourful decor and appropriate furnishings and fittings. The centre was clean and reasonably well maintained and had been refurbished in parts since the last inspection.

Furniture and equipment seen in use by residents was in good working condition and appropriate to their needs. Service records were available to confirm this.

Supportive equipment such as call-bell facilities, remote control beds and pressure relieving aids were seen in use by residents.

Bedrooms were reasonably spacious to accommodate personal equipment and devices required by existing residents. Handrails were provided on corridors, and grab-rails were available in bathrooms and toilets. All bedrooms, bathrooms and communal areas were fitted with a call bell system, and a display panel in the sitting room outside the nurse’s office identified the location of a call.

Residents were encouraged and availed of the opportunity to have personal mementos and processions in their own bedrooms. Many of the bedrooms had pictures and family photos on display, while the art work completed by residents was seen on display along each corridor.

While many premises issues highlighted in previous inspections were addressed, a significant requirement in relation to the design and layout of the sitting and dining room remained outstanding and required improvement.

The height of the skylight windows in the current sitting room were residents occupy all day does not enable residents to see outside when seated or in a standing position. This is the main day room where residents congregate or participate in activities. It is also used by approximately 50% of residents to dine in, while the dining room catered for up to 9 residents during this inspection. A plan to extend the premises to address the
sitting and dining room deficiencies was being progressed in order to accommodate the number and needs of all residents. The architects engaged with the provider met with the inspector, maintenance person and the person in charge during the inspection to discuss a plan they had proposed. They demonstrated they had familiarised themselves with the standards and had read previous inspection reports. As a result of the meeting, all parties were clear on the requirement by the provider to submit written costed time bound plans to the Chief Inspector along with the action plan response for consideration in the application to renew the centre’s registration.

Matters that had been addressed since the previous inspection included the following:-

- the resident’s alarm call system was functioning and operational throughout the centre
- storage arrangements for residents’ clothing had improved, by the provision of locker facilities with a lockable storage compartment.

A system for reporting maintenance was described and a record was available, however, the recording practices required improvement to ensure all items in need of repair, such as a malfunctioning cupboard lock and broken glass pane seen in a resident’s bedroom, were reported for address in a timely fashion.

There were heating arrangements and hot water facilities throughout the centre. However, the room temperature in parts was cold or draughty such as in the internal nurse’s office and shower room which was attributed to dated ski-light windows. In addition, the inspector saw and highlighted to management that a gap between the closed doors to the main entrance also caused a notable draught resulting in heat loss, a draught when seated in the front hall and a cool air temperature was noted in the corridors. Room temperature gauges to enable an audit of affected areas was required.

In the main sitting room a damp patch was noted on the surface below one ski-light window and the blinds on up to four of the ski-light windows were in need of repair or replacement to function as intended. The management team acknowledged these findings and said it would be included in the refurbishment programme.

A dedicated visitor’s room where residents could meet in private and separate from their bedrooms and other communal areas was available.

The main kitchen was observed in operation prior to lunchtime. However, it was not inspected as the inspector noted that it was subject to inspections by an environmental health officer who had reported their findings in July 2016.

Sufficient car parking facilities were available at the centre.

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
Theme: Person-centred care and support

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

Findings:
The inspector saw that there were policies, procedures, systems and practices in place for the management of complaints or concerns.

The complaints procedure was displayed in the entrance hall to the centre, and residents who communicated with the inspector were aware of the process and identified the person with whom they would communicate with if they had an issue of concern.

Both the person in charge and deputy stated that they were open to receiving complaints or information in order to improve the service. A log of issues or complaints received was maintained in accordance with the prescribed regulations. There was one minor complaint since the previous inspection that had been resolved to the satisfaction of the complainant.

Judgment:
Compliant

Outcome 14: End of Life Care
Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

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 policy and operational procedures for end of life were in place and available to guide staff and inform care practices. At the time of inspection, the inspector was informed that any resident approaching the end of life had a care plan in place that had been discussed with them or their representative and their GP.

Involvement of a multi-disciplinary approach to treatment and care that included a palliative care team was available but not required by any of the current residents at this time.
Medical decisions regarding care and treatment decisions at the end of life were recorded, and the inspector found evidence that the residents’ wishes for end of life were discussed during the assessment and review process.

Caring for a resident at end of life was regarded by staff as an essential part of the care service provided. Choices were offered and facilities were available to support residents and families as required. Facilities available to families or next of kin included the visitor’s room. Staff provided refreshments where suitable.

An oratory facility was not available in the centre but in the past the use of the visitor’s room as an area of repose was facilitated based on resident or family preferences and wishes. The inspector was told by staff that this arrangement offered other residents and staff ‘to say their goodbye’.

The inspector saw suitable equipment and religious artefacts available that respected residents’ cultural and religious background. This included specific arrangements and symbols to alert staff, residents and visitors that a resident was at end of life, specific handover bags for the return of possessions and the provision of important relevant information to grieving relatives to address the findings of the last inspection.

Residents and staff told the inspector that the local priest visited the centre weekly and other priests on holiday in the locality often visited to celebrate religious occasions. A church of Ireland minister also visited, as required.

**Judgment:**
Compliant

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**Outcome 15: Food and Nutrition**

*Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.*

**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:**
Mealtimes observed were unhurried social occasions that provided opportunities for residents to interact with each other and staff. However, as previously reported and discussed in outcome 12, improvement in relation to the dining space and arrangements was needed as the current arrangements did not provide any different stimulation with regard to moving from one environment to another.
Staff were seen assisting and supporting residents appropriately, in a discrete and respectful manner. Nine residents were seen comfortably seated in the dining room for lunch on the first day of the inspection while others were facilitated and supported in the sitting room where they were seated throughout the day.

Staff preparing, serving and assisting with meals and drinks were familiar with residents' dietary requirements, needs and preferences. Staff offered choices and checked resident were satisfied during mealtimes.

Systems were in place to ascertain residents’ views and preferences from a varied menu on a daily basis.

There was a policy in place to guide practice and clinical assessment in relation to monitoring and recording of weights, nutritional intake and risk of malnutrition. Staff were knowledgeable and described practices and communication systems in place to monitor residents that included regular weight monitoring, recommended food and fluid consistency and arrangements for intake recording, if required. The inspector saw that recommendations by a dietician or speech and language therapist formed part of the care plan to address previous findings.

Communication systems were in place to ensure that residents' nutritional and care needs were known by staff supporting residents to eat and drink and to those preparing and serving food. Details of residents’ specific dietary needs was maintained by staff and provided to the kitchen as required.

Systems were in place to ascertain each resident’s food preferences on admission, and the residents’ forum was used to provide feedback on topics including the menu options and choices, in order to inform improvements.

Access to dietician and speech and language therapists was provided on a referral basis based on an assessment of need or change in resident condition. Residents were provided with food and drink at times and in quantities adequate for their needs. The food was properly served and presented in an appetising way.

Menus showed a variety of choices at mealtimes, and the menu choice was on display in the sitting room.

There was sufficient numbers of staff on duty to offer assistance to residents in a discreet and sensitive manner. There was an emphasis on residents' maintaining their own independence and appropriate equipment was provided to support this. Residents confirmed their satisfaction with mealtimes and food provided.

Snacks and beverage were offered and available to residents at intervals between main meals.

**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):
No actions were required from the previous inspection.

Findings:
There was evidence that residents were consulted with and had opportunities to participate in the organisation of the centre. A residents' committee/forum was facilitated on a regular basis, and family or representative involvement was central to the care and services provided.

Information in relation to independent advocacy services was available to residents and on display on a notice board. Residents’ independence and autonomy was promoted. Outings with family and access to the local town was encouraged and facilitated to enhance engagement in the wider community.

Residents who spoke with the inspector and those who completed questionnaires said they were able to make decisions about their care and had choices about how they spent their day, when and where they ate meals, and when they rise from and return to bed. Residents had options to meet visitors in a private or communal areas based on their assessed needs.

The inspector established from speaking with residents, visitors and staff that opportunities to maintain personal relationships with family and friends in the wider community was encouraged. Visitors described the centre as ‘home from home’ and were always made feel welcomed. They also reported and described unrestricted access as discussed in outcome 8.

Arrangements were provided for residents to attend external appointments or family occasions and maintain links with the religious or wider community. Overall, the arrangements in place promoted social inclusion, engagement and access to external facilities.

Communication aids, telephones and computers were available to residents. Mass was streamed live on a daily basis from the local church and residents said how important this was to them.

The inspector saw that residents’ privacy and dignity was respected: and personal care was provided mainly in their bedrooms during the inspection. Staff worked to ensure that residents received care in a dignified way that respected their privacy and were
observed knocking on bedroom and bathroom doors prior to entering.

Residents were seen to be well groomed and dressed in an appropriate manner with clothes and personal effects of their choosing. Residents who spoke with the inspector and those who completed questionnaires said they were respected, consulted with and well cared for by friendly, pleasant and kind staff.

**Judgment:**
Compliant

**Outcome 17: Residents’ clothing and personal property and possessions**
*Adequate space is provided for residents’ personal possessions. Residents can appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.*

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

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

**Findings:**
Records of residents’ property were maintained.

The inspector saw that there was adequate space provided for residents’ personal possessions and mobility aids. Residents had a lockable facility in their bedrooms.

There were arrangements offsite for regular laundering of linen and clothing and the safe return of clothes to residents.

**Judgment:**
Compliant

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

**Theme:**
Workforce

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

**Findings:**
Staffing levels and the skill mix were sufficient to meet the healthcare needs of the residents; however, social activities required improvement. The inspector was told by staff that the recruitment of an activity person was underway to replace a vacancy they had since Christmas. Residents told the inspector that they hoped this vacancy would be soon be filled because they missed the structured activities and were limited to two hours on two afternoons. Although they enjoyed what was provided by staff they felt they needed the vacancy filled.

Staff on duty confirmed that they had sufficient time to carry out their duties and responsibilities, and the management team explained the systems in place to supervise and appraise staff. Staff were seen to be supportive of residents and responsive to their needs.

In preparation for the inspection, relatives and some residents had completed 14 questionnaires regarding the centre. In these questionnaires, respondents were extremely complimentary regarding the staff team. The inspector also spoke with a number of residents and relatives visiting who were all complimentary of the staff and of the care that they provided.

The inspector reviewed the actual and planned roster for staff and found that management, nursing, care and support staff were adequate. Requests and residents’ alarm bells were promptly responded to by staff during the inspection. Residents chose the time that they wished to get up, eat and seek assistance with personal care and dressing, and this was facilitated by the staff team.

Some residents in discussions with the inspector confirmed that staffing levels were satisfactory and that staff were supportive and helpful when needed.

Recruitment procedures were in place and samples of staff files were reviewed against the requirements of schedule 2 records and found non-compliant, as reported in outcome 5. Administration support as a resource was required, as previously reported on the last inspection under outcome 2.

Evidence of professional registration for all rostered nurses was available and current.

The inspector was satisfied with the arrangements for appraisal and supervision of staff. A staff training programme was in place and a record of training for all staff was available. Relevant training such as dementia awareness and mandatory training such as moving and handling, fire training and the prevention, detection and management of abuse had been provided. Manual handling practices observed were safe and appropriate, with assistive equipment available for use. However, an improvement was required to ensure all staff had received mandatory and relevant training that included cardio pulmonary resuscitation (CPR), manual handling refresher training, missing person and fire drills.
Staff were seen to be kind and friendly towards all residents and respectful towards their privacy and dignity. For example, knocking on residents' bedroom doors and waiting for permission to enter.

The inspector was informed that there were no volunteers in the centre. The centre did not utilise agency staff.

**Judgment:**
Non Compliant - Moderate

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**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Sonia McCague
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Our Lady of Consolation Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000079</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>13/02/2017</td>
</tr>
<tr>
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<td>09/03/2017</td>
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Requirements

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

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

Outcome 01: Statement of Purpose

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The Statement of purpose required revision to include details of specified fees and staff compliment including those working in the centre as maintenance and administration staff.

1. Action Required:
Under Regulation 03(2) you are required to: Review and revise the statement of

1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
Statement of purpose is now revised to include details of the fees and staff compliment including maintenance and administration staff. Copy of the revised statement of purpose attached with this report.

Proposed Timescale: 20/02/2017

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:
A copy of the final as-built or as-is floor plan was required to reflect the facilities available as the one submitted did not specify or make clear the number of bathrooms and toilet facilities located along each corridor.

2. Action Required:
Under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 you are required to: Provide all documentation prescribed under Regulation 4 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015

Please state the actions you have taken or are planning to take:
A copy of the final as-built/ as-is floor plan is attached with this report which specify the number of bathrooms and toilet facilities located in the nursing home.

Proposed Timescale: 24/02/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvement was needed, as previously reported and agreed, to address the administration requirements and provision of schedule 2 records for all persons working in the designated centre.

The provider was required to submit a costed time-bound plan to address the deficiencies of the design and layout of the premises.

3. 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
Please state the actions you have taken or are planning to take:
Person In charge had reviewed records of all employees and schedule 2 records are in place for all the persons working in the centre.

Proposed Timescale: 03/03/2017

Outcome 03: Information for residents
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Following the amendment to the Regulations in June 2016 the PIC agreed to amend the contract of care template to include terms relating to the bedroom to be provided and the number of occupants to be accommodated within the bedroom provided.

4. Action Required:
Under Regulation 24(1) you are required to: Agree in writing with each resident, on the admission of that resident to the designated centre, the terms on which that resident shall reside in the centre.

Please state the actions you have taken or are planning to take:
The person in charge had amended the Contract of care to include the bedroom to be provided and the number of occupants to be accommodated within the bedroom provided (Page 15). A copy of the same attached with this report.

Proposed Timescale: 21/02/2017

Outcome 05: Documentation to be kept at a designated centre
Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge was to review the details in each policy to ensure they could be implemented in practice, as discussed in outcome 8.

5. Action Required:
Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

Please state the actions you have taken or are planning to take:
All the policies are reviewed by the person in charge and they could be implemented to
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector found gaps and an absence of the required records such as a record of a vetting disclosure in accordance with the National Vetting Bureau for 3 staff members recruited after 29 April 2016. This was also a finding on the previous inspection. The person in charge, as provider nominee, gave verbal and written assurances that any person without Garda vetting would not be working or rostered to work in the centre. Following the inspection, she submitted written confirmation that all staff had completed Garda vetting.

An absence of two written references, including a reference from a person’s most recent employer.

Absence of a contract or record that detailed the dates on which staff commenced or ceased employment and the position they held was not available for some staff.

A record of all visitors to the centre on the first day of the inspection was not completed or maintained.

Improvement was required to ensure completeness as follows:
• a record of assessment or treatment to residents by practitioners attending residents in a private or public capacity should be maintained and recorded on a separate document pertaining to individual residents
• the logging of maintenance requests required improvement to ensure the responsible person is notified to ensure a timely response.

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

Please state the actions you have taken or are planning to take:
   a. Person In charge had reviewed records of all employees and schedule 2 records are in place now for all the persons working in the centre.

   b. This report was discussed during the residents committee meeting and Person in charge informed all the residents and their next of kin the importance of maintaining the visitors’ book. All the staff are informed to remind the visitors coming in to enter and exit their names in the visitors book. The person In charge will monitor the same on a weekly basis to ensure compliance.
c. A separate document has been developed for practitioners attending to residents to record of their assessments for individual residents.

Proposed Timescale: a. 03/03/2017  
b. 25/02/2017  
c. 28/02/2017

Proposed Timescale: 03/03/2017

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:
The inspector found that the provider or person in charge did not have sufficient control over the entry and exit of visitors as many had a key that enabled them to enter to the centre at any time. This arrangement was discussed with the provider representatives, person in charge and deputy who acknowledged the risk to residents and staff, which resulted in action taken prior to the completion of the inspection to mitigate the identified risk.

Further assessment and consideration was to be given to the control of entry and exit.

7. 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:
We have changed the locks of the front doors since and the visitors have to ring the bell for assistance to enter into the Nursing Home.

Proposed Timescale: 07/03/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Emergency evacuation equipment such as ski sheets or pads were not available and bedroom door widths did not facilitate the removal of a bed.

The recently implemented emergency fire policy included the provision and use of ski sheets in accordance with a personal emergency evacuation plan (PEEP) for each
resident. However, these arrangements were not available, in place or recorded.

8. **Action Required:**
Under Regulation 28(1)(d) you are required to: Make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.

**Please state the actions you have taken or are planning to take:**
Personal Emergency Evacuation Plan is in place for all the residents now. Wall mounted evacuation mattress are made available for each zone now which can be used for emergency evacuation for bed bound residents.

**Proposed Timescale:** 07/03/2017

**Theme:**
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provision of fire drills to residents and staff, and the recording practices required further improvement to ensure a drill simulating evening and night time conditions was practiced that identified those involved, the duration, successes or failures and equipment available or used.

9. **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:**
We have improved the recording practices to specify the fire drill simulating times (evening or night time), the duration, successes or failures and equipment available or used.

**Proposed Timescale:** 07/03/2017

**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:
The most recent quarterly report submitted was incomplete in parts and quarterly notifications for the second and third quarter of 2016 had not been notified to the Chief
10. **Action Required:**
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

**Please state the actions you have taken or are planning to take:**
The person in charge apologizes for the gap in the quarterly notifications in the second and third quarter of 2016, same is forwarded to the authority now.

**Proposed Timescale:** 08/03/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A nil return was not submitted for or during 2016.

11. **Action Required:**
Under Regulation 31(4) you are required to: Where no report is required under regulation 31(1) or 31(3), report this to the Chief Inspector at the end of each 6 month period.

**Please state the actions you have taken or are planning to take:**
The person in charge apologizes for the gap in the quarterly notifications in the second and third quarter of 2016, same is forwarded to the authority now.

**Proposed Timescale:** 08/03/2017

**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:**
A significant requirement in relation to the design and layout of the sitting and dining room remained outstanding. The provider is required to submit a written costed time-bound plan to the Chief Inspector along with the action plan response for consideration in the application to renew the centre’s registration.

The height of the skylight windows in the current sitting room were residents occupy all day, does not enable residents to see outside when seated or in a standing position. This is the main day room where residents congregate or participate in activities. It is also the room where approximately 50% of residents to dine, while the dining room
catered for up to 9 residents during this inspection. A plan to extend the premises to address the sitting and dining room deficiencies was being progressed in order to accommodate the number and needs of all residents.

The maintenance recording practices required improvement to ensure all items in need of repair, such as a malfunctioning cupboard lock and broken glass pane seen in a resident’s bedroom, were reported for address in a timely fashion.

The room temperature in parts was cold or draughty such as in the internal nurse’s office and shower room which was attributed to dated ski-light windows.

A gap between the closed doors to the main entrance caused a notable draught resulting in heat loss, a draught when seated in the front hall and a cool air temperature in the corridors. Room temperature gauges to enable an audit of affected areas was required.

A damp patch was noted on the surface below one ski-light window in the main sitting room and the blinds on up to four of the ski-light windows were in need of repair or replacement to function as intended.

The management team acknowledged these findings and said it would be included in the refurbishment programme.

12. **Action Required:**
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

**Please state the actions you have taken or are planning to take:**
- a. A copy of our plans for extension drawn by our architect is attached with this report.
- b. We have initiated a diary to record and to report any maintenance needs on a daily basis. The person responsible for maintenance informed to acknowledge the maintenance needs on the diary.
- c. We have made plans to repair the skylight windows to avoid any draughts or heat loss caused by the skylight windows.
- d. The closed front doors and the windows in the lounge will be upgraded to reduce any heat loss or draughts.
- e. The blinds of the ski-light windows will be repaired.

**Proposed Timescale:**
- a. 31/01/2018
- b. 20/03/2017
- c. 30/06/2017
- d. 31/07/2017
- e. 30/06/2017
Proposed Timescale: 31/01/2018

**Outcome 18: Suitable Staffing**

**Theme:**
Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Staffing levels to support social activities required improvement. The inspector was told by staff that the recruitment of an activity person was underway to replace a vacancy they had since Christmas.

Residents told the inspector that they hoped this vacancy would be soon be filled because they missed the structured activities and were limited to two hours on two afternoons. Although thoroughly enjoyed what was provided by staff they felt they needed the vacancy filled.

**13. 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:**
We have recruited an activity person, received vetting disclosure and schedule 2 documents. She will commence her employment on the 10th of March 2017.

Proposed Timescale: 10/03/2017

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Improvement was required to ensure all staff had received mandatory and relevant training that included cardio pulmonary resuscitation (CPR), manual handling refresher training, missing person and fire drills.

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

**Please state the actions you have taken or are planning to take:**
All the mandatory trainings are up to date now and we have arranged training for Cardio Pulmonary Resuscitation on the 22nd of March 2017

Proposed Timescale: 22/03/2017
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<th>Theme:</th>
<th>Workforce</th>
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<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Staff files were incomplete against the requirements of schedule 2 records, as previously reported.</td>
</tr>
<tr>
<td><strong>15. Action Required:</strong></td>
<td>Under Regulation 16(1)(c) you are required to: Ensure that staff are informed of the Act and any regulations made under it.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>Person In charge had reviewed records of all employees and schedule 2 records are in place for all the persons working in the centre.</td>
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<td><strong>Proposed Timescale:</strong></td>
<td>03/03/2017</td>
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