Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Kenmare Nursing Home 'Tir na nOg'
Centre ID:	OSV-0000239
Centre address:	Killaha East, Kenmare, Kerry.
Telephone number:	064 664 1315
Email address:	nursinghome@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Tim Harrington
Lead inspector:	John Greaney
Support inspector(s):	None
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	3

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:
09 April 2019 10:00	09 April 2019 18:00
10 April 2019 08:45	10 April 2019 17:00

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	Compliance demonstrated	Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Compliance demonstrated	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Compliance demonstrated	Substantially Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Major
Outcome 12: Notification of Incidents		Substantially Compliant

Summary of findings from this inspection

Kenmare Nursing Home 'Tir na nOg' is a 27 bedded nursing home located approximately two kilometres from Kenmare town. It is situated on a raised site with panoramic views, overlooking Kenmare bay. The centre accommodates twenty seven residents in thirteen single bedrooms and seven twin bedrooms. A recent extension to the centre involved the construction of ten single bedrooms, all of which are en suite with toilet and wash hand basin. The older part of the centre comprises seven twin bedrooms, two of which are en suite with toilet and wash hand basin and the remaining bedrooms, three single and five twin, have a wash hand basin only in the

room.

The purpose of this inspection was to focus on the care and quality of life for residents with dementia living in the centre. 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 these are included in this inspection report.

Thirteen of the twenty four residents who were living in the centre on the days of the inspection had a diagnosis of dementia. The provider had submitted a completed self-assessment on dementia care to HIQA with relevant policies and procedures prior to the inspection. The judgments from both the self-assessment and the inspection are set out in the table above.

The journey of a sample of residents with dementia within the service was tracked. The inspector reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies, including those submitted by the centre prior to this inspection as part of their self-assessment documentation. As part of the inspection process, the inspector spent a period of time observing staff interactions with residents. The Inspector used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. Overall, the inspector observed that interactions by staff with residents were predominantly respectful and caring. While there were improvements noted since the last inspection, the social experience of residents could be enhanced through the provision of a more structured and varied programme of activities.

All residents spoken with stated that they felt safe in the centre. Where there were suspicions or allegations of abuse, these were recorded and investigated. Safeguarding measures were put in place while the investigation was on-going. However, on one occasion this was not notified to the Office of the Chief Inspector, as required. There were adequate measures in place to safeguard residents' finances through appropriate record keeping and receipts.

Care plans were seen to be personalised and provided good guidance on the care to be delivered. A sample of care plans reviewed adequately addressed issues such as wound care and the communication needs of residents. Care was provided to residents as they approached end of life to a good standard. Care was usually provided by nursing and care staff, supported by the resident's GP. When required, there was good access to palliative care. Relatives and friends were supported to remain in the centre, should they so wish.

Fire safety practices were reviewed in the context of following up on issues identified on a previous inspection. Through this process it was identified that adequate emergency lighting was not in place in the older section of the premises. It was also noted that the fire alarm and emergency lighting in the new wing did not have preventive maintenance completed since they were commissioned. A review was also required of fire doors in relation to their ability to contain fire and smoke in the event of a fire. Due to the risk associated with these findings, an urgent action plan was

issued to the provider requesting that these issues be addressed urgently.

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, assessments and care planning. The social care of residents with dementia is discussed in Outcome 3.

The centre is registered to accommodate 27 residents and there were 24 residents in the centre on the day of the inspection. The inspector focused on the experience of residents with dementia and tracked the journey of a number of residents with dementia. Thirteen residents had a formal diagnosis of dementia.

The inspector saw that residents had a choice of GP and a number of local GP's visited the centre on a regular basis. A review of a sample of records indicated that residents were reviewed regularly by their GP. The records confirmed that residents were assisted to achieve and maintain the best possible health through medical reviews, laboratory tests and annual administration of the influenza vaccine. Residents that qualified for national screening programmes, such as retinal screening for diabetics, were supported to participate in the programme should they so wish. Residents had access to allied healthcare professionals including physiotherapy, dietetics, speech and language therapy, chiropody and opticians.

The person in charge visited residents that were to be admitted from local facilities to carry out a pre-admission assessment, to determine if their needs could be met in the centre. Residents that were admitted from facilities that were further afield were assessed remotely using information garnered from families, discharge coordinators and general practitioners (GPs). Residents and their families were also invited to visit the centre prior to admission, if possible. When residents were admitted from hospital or transferred to hospital, there were adequate systems in place to optimise communication between the resident/families, the acute hospital and the centre. Hospital discharge documentation was held for residents admitted to the centre from hospital to inform their treatment plans and on-going care needs.

The inspector saw that residents had a comprehensive nursing assessment completed on admission. The assessment process involved the use of a variety of evidenced based

validated tools to assess each resident's risk. Examples of assessments included, the risk of malnutrition, the risk of falling, the risk of pressure related skin injury, and the level of cognitive impairment. Care plans were developed for residents based on their assessed needs. A sample of care plans reviewed contained the required information to guide the care and were regularly reviewed and updated to reflect residents' changing needs. Overall, care plans were person-centred. Staff spoken with had a good knowledge and understanding of residents' needs, likes and dislikes.

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 and assessed for the risk of malnutrition on admission and at regular intervals thereafter, using a validated tool. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. The inspector found that residents on diabetic diets, modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served.

Breakfast was served for most residents from 08:30hrs but a small number of residents had breakfast in their bedrooms earlier. Choice of food was available at mealtimes, including for residents on a modified diet. Meals appeared to be nutritious and were attractively presented by catering staff.

Staff provided end-of-life care to residents with the support of their GP and community palliative care services, as necessary. There was evidence of discussion with residents in relation to their preferences for end of life care. Records indicated that, where possible, residents were involved in this decision-making process. A pain assessment tool suitable for residents who were unable to verbalize their levels of pain was available and implemented in practice. Residents' relatives were facilitated to stay overnight with them when they became very ill. Staff outlined how residents' religious and cultural needs were facilitated. Members of the local clergy provided pastoral and spiritual support to residents as they wished.

There was a centre-specific medication policy with procedures for safe ordering, prescribing, storing and administration of medicines. All residents had photographic identification in place. The supply and administration of scheduled controlled drugs was checked and was correct against the drug register, in line with legislation. Two nurses checked the quantity of these medications at the start of each shift. The nurse, spoken with by the inspector, displayed a good knowledge of the requirements in the area of controlled drugs and the responsibilities of the registered nurse to maintain careful records.

Medications in the centre were supplied in a monitored dosage system. There was a system of reconciliation to ensure that what was delivered matched the prescription. A review of a sample of prescriptions indicated that nurses transcribed medications. Improvements were noted in transcription practice since the last inspection and transcription now complied with relevant guidance.

Judgment:
Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
Measures were in place to safeguard and protect residents with dementia from abuse. There was a policy and procedure in place to inform the prevention, detection and response to any allegations, disclosures or incidents of abuse in the centre. Systems were in place to ensure that allegations of abuse were fully investigated, and that residents were safeguarded during the investigation process. Staff spoken with on the days of this inspection could describe how they would identify and respond to allegations of abuse. It was reiterated to the person in charge and the provider that staff should be encouraged to report suspicions of abuse at the earliest opportunity. Residents told the inspector that they felt safe in the centre and spoke positively about the staff caring for them. All interactions by staff with residents observed by the inspector were kind and respectful.

There was a policy and procedure in place for the management of responsive behaviour. The inspector was told that a small number of residents with dementia were predisposed to experiencing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). With the exception of one resident needing support with managing their responsive behaviours, all other residents were stable at the time of this inspection. Staff were familiar with triggers to this resident's behaviours and were observed using the most appropriate person centred interventions to de-escalate behaviours.

A policy to inform management of restraint was available and reflected procedural guidelines in line with the national restraint policy. Risk assessments to ensure safe use of bedrails and records of any decision-making were completed in line with national policy and guidance. Safety checks were carried out for residents when bedrails were in place. The restraint register documented use of restraint, including full-length bedrails.

There were systems in place for the management of residents' finances. The inspector was informed that the provider was not pension agent for any resident. The procedures in place were reviewed and the inspector found that satisfactory records were maintained.

Judgment:
Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

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

Findings:
Residents were consulted about how the centre is planned and run. The person in charge stated that residents' meetings had been ineffective and minimal feedback was obtained in relation to residents' views on life in the centre. These had been replaced with family meetings, whereby a meeting was arranged with residents and their families every six months. In addition to reviewing the resident's care plan at these meetings, it was also used as an opportunity to obtain feedback in relation to day to day operation of the centre.

Residents are facilitated to exercise their civil, political, religious rights and are enabled to make informed decisions about the management of their care through the provision of appropriate information. Residents were supported to vote in national and local elections. Mass was held in the centre on a monthly basis and there was also a link to the local church, whereby residents could view church services through a closed circuit television (CCTV) link. On the day of the inspection residents were watching a confirmation service in the church.

While there was a programme of activities, the programme lacked variety and was not geared towards stimulating and occupying residents with dementia. Information on residents' interests were contained in documents such as "A Key to Me" and "My Day, My Way", however, it was not evident that this information contributed to the development of the programme of activities. On both days of the inspection, the more independent residents were seen to be playing skittles, participating in singing, playing cards and colouring pictures. Observations of the inspector indicated that residents, particularly those with a cognitive impairment or dementia, would benefit from more sensory activities. While residents appeared to enjoy music, there was little else in respect of sensory-based activities scheduled. The inspector observed that some residents were given sheets of paper with images to be coloured in, but some were given pens that were not suitable for that purpose. It was also evident that some of these residents did not have a particular interest in this activity. Some activities were facilitated by external people, such as chair based exercises by a physiotherapist, a singer visited approximately twice weekly and a pet farm that visited monthly.

A record of visitors to the designated centre was maintained. Visitors were seen to come and go throughout the two days of the inspection and it was evident that there was a welcoming atmosphere for visitors. Residents said they were able to exercise choice regarding the time they got up and went to bed. Breakfast was served at a time that suited them. Most residents opted to have dinner and evening meals in the dining room.

The inspector found that residents' privacy and dignity was respected. The staff were observed knocking on bedroom and bathroom doors and waited for permission before they entered. They were heard explaining why they were coming into their room, for example, to give medications or to assist the resident with care. Screens were provided in the shared bedrooms and they were observed to be in use when personal care was being provided.

As part of the inspection, the inspector spent a period of time observing staff interactions with residents with a dementia using a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five-minute intervals the quality of interactions between staff and residents. The observations took place in the main sitting room and the dining room. Overall, the inspector observed staff to be respectful in all of their interactions with residents. It was observed, however, that opportunities to engage with the more dependant and less communicative residents was not always taken, particularly during mealtimes. Staff were also observed to mix all of the food together for residents that were prescribed a modified texture diet, which is not in keeping with promoting dignity.

Judgment:
Substantially 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:
A written complaints policy was available in the centre and the inspector saw that the complaints procedure was on display in a prominent place. There was a nominated person to deal with complaints in the centre and a second nominated person to monitor and ensure that all complaints were appropriately responded to. The complaints procedure included an independent appeals process.

The inspector reviewed the complaints log and found the complaints process was in place to ensure the complaints of residents, their families or next of kin including those with dementia were listened to and acted upon. Residents and relatives confirmed that there were no barriers to reporting complaints to any member of staff.

There was evidence that the person in charge monitored complaints or any issues raised by being readily available and regularly speaking to residents, visitors and staff. Records showed that complaints made to date were dealt with promptly and the outcome and satisfaction of the complainant was recorded, as required by the regulations.

Judgment:
Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
The inspector observed staff providing care in a respectful manner. Residents appeared to be familiar with staff.

An actual and planned roster was maintained in the centre, with any changes clearly indicated. There was a regular pattern of rostered care staff. In addition to the person in charge, there was one staff nurse on duty each day and one staff nurse on night duty. There were six healthcare assistants on duty each morning, three in the afternoon, two in the evening and one at night. There was also a chef, two housekeeping staff, a manager, an administrative staff member and a maintenance staff member. Staff spoken with confirmed that they had sufficient time to carry out their duties and responsibilities.

A review of staff files indicated that recruitment practices did not at all times comply with the requirements of Schedule 2 of the regulations. For example, the employment history for one member of staff only detailed employment in Ireland and there was no explanation for the absence of employment or education history for the period immediately prior to arrival in Ireland. Additionally, the employment history recorded in the curriculum vitae did not correlate with dates contained in a reference for a member of staff. While all staff members had a Garda vetting disclosure in place, records indicated that these were not in place for all members of staff on the date they commenced work in the centre. Evidence of current professional registration for registered nurses was seen by the inspector.

There were induction procedures in place for new staff. New staff spent time in a supernumery capacity working alongside a long term member of the team. There was also a process of appraisal for existing staff. All staff spoken with felt supported by the management team.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
Kenmare Nursing Home 'Tir na nOg' is a 27 bedded nursing home located approximately two kilometres from Kenmare town. It is situated on a raised site with panoramic views, overlooking Kenmare bay.

The centre accommodates twenty seven residents in thirteen single bedrooms and seven twin bedrooms. A recent extension to the centre involved the construction of ten single bedrooms, all of which are en suite with toilet and wash hand basin. The older part of the centre comprises seven twin bedrooms, two of which are en suite with toilet and wash hand basin and the remaining bedrooms, three single and five twin, have a wash hand basin only in the room. Two of the twin bedrooms are marginal in size and can only accommodate residents that do not require assistive equipment, such as a hoist, to get in or out of the bed.

In addition to en suite toilets, sanitary facilities comprise three bathrooms with shower, toilet and wash hand basin and two bathrooms with toilet and wash hand basin. The hand rail in at least one of the bathrooms required review as sections of it were rusted. Communal facilities comprised a large sitting room and a large dining room, both of which had been extended when the new extension was built. There is also a small visitors room. There is an enclosed patio to the rear of the centre with garden furniture. Secure outdoor space is limited and there is no area in which residents can walk freely should they so wish. On previous inspections the inspector was informed that there were plans for a garden at the front of the centre, however, these plans had not been progressed.

Corridors were narrow in the older part of the premises and if a resident was using assistive equipment such as a walking frame, it would be extremely difficult for another resident to get by, should they meet on the corridor. The inspector was informed that the centre was recently painted, however, there were scuff marks and damaged paintwork particularly on door frames. Some bedrooms were personalised with photos, memorabilia and artefacts. Furniture and equipment for use by residents was in good working condition and appropriate to their needs. Records of preventive maintenance of equipment, such as beds and hoists, were available for review. Handrails were available in all circulation areas throughout the building, and grab rails were present in all toilets and bathrooms.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

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

Findings:
As part of the inspection the inspector reviewed issues that were identified on a previous inspection to determine if they had been satisfactorily addressed. While it was found that these issues were addressed, a number of other issues were identified on this inspection.

While there was certification to state that the emergency lights in the older section of the premises had preventive maintenance, it was noted that the only lighting available in this section of the premises were lights over emergency exits. There were no emergency lights in the bedrooms, hallways, sitting room, kitchen or staff room. It was also found that preventive maintenance had not been carried out on the fire alarm or the emergency lights in the newly constructed wing since they were commissioned over one year ago.

Other issues found on this inspection included:
• cross corridor fire doors in both the old and new wings required review to ensure they provided an effective barrier against the spread of smoke and flames in the event of a fire
• bedroom doors were held open using furniture such as chairs and bedside tables

There were two separate fire alarm systems in the centre, one which covered the older section of the premises and the second covered the new wing. The provider was requested to review these systems to ensure they adequately detect, contain and give warning of fires throughout the centre.

Due to the risk associated with these findings, an urgent compliance plan was issued to the provider to address these findings.

Judgment:
Non Compliant - Major

Outcome 12: Notification of Incidents

Theme:
Effective care and support

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

Findings:
A review of records and discussions with the person in charge indicated that not all incidents requiring notification to the Office of The Chief Inspector were submitted within the required time frame.

Judgment:
Substantially Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

John Greaney
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	Kenmare Nursing Home 'Tir na nOg'
Centre ID:	OSV-0000239
Date of inspection:	09/04/2019
Date of response:	23/05/2019

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 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was observed that opportunities to engage with the more dependant and less communicative residents was not always taken, particularly during mealtimes. Staff were also observed to mix all of the food together for residents that were prescribed a modified texture diet, which is not in keeping with promoting dignity.

1. Action Required:

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

Under Regulation 09(1) you are required to: Carry on the business of the designated centre with regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.

Please state the actions you have taken or are planning to take:
All staffs have attended training for Dysphagia. In our staff meeting, all staff were informed not to mix foods together, and were told to communicate more with residents who were less communicative especially at meal times.

Proposed Timescale: 10/04/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
While there was a programme of activities, the programme lacked variety and was not geared towards stimulating and occupying residents with dementia. Observations of the inspector indicated that residents, particularly those with a cognitive impairment or dementia, would benefit from more sensory activities.

2. Action Required:
Under Regulation 09(2)(b) you are required to: Provide opportunities for residents to participate in activities in accordance with their interests and capacities.

Please state the actions you have taken or are planning to take:
We have a new member of staff who is an experienced person and has FETAC level 5 in activities. She does planned/exploratory/sensory and reflex activities for residents with dementia e.g.Sonas with the help of another activity staff member.

Proposed Timescale: 02/05/2019

Outcome 05: Suitable Staffing

Theme:
Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
A review of staff files indicated that recruitment practices did not at all times comply with the requirements of Schedule 2 of the regulations. For example:
• the employment history for one member of staff only detailed employment in Ireland and there was no explanation for the absence of employment or education history for the period immediately prior to arrival in Ireland
• the employment history recorded in the curriculum vitae for one member of staff did not correlate with dates contained in a reference for that member of staff
• while all staff members had a Garda vetting disclosure in place, records indicated that

this was not in place for one member of staff on the date they commenced work in the centre.

3. 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:
• For future staff we will ensure to check employment & education history for any country prior to arrival in Ireland.
• We will double check all CV's & references to make sure that the dates correlate
• In future we will ensure all staff members Garda vetting is in place before commencement of work

Proposed Timescale: 10/04/2019

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The inspector was informed that the centre was recently painted, however, there were scuff marks and damaged paintwork particularly on door frames.

4. 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:
We have started painting inside the building again and will concentrate on the door frames first.

Proposed Timescale: 14/06/2019

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:
While there was certification to state that the emergency lights in the older section of the premises had preventive maintenance, it was noted that the only lighting available

in this section of the premises were lights over emergency exits. There were no emergency lights in the bedrooms, hallways, sitting room, kitchen or staff room.

5. Action Required:
Under Regulation 28(1)(b) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
Emergency lighting is now in all rooms & corridors in old section of the building

Proposed Timescale: 18/04/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
It was found that preventive maintenance had not been carried out on the fire alarm or the emergency lights in the newly constructed wing since they were commissioned over one year ago.

6. Action Required:
Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

Please state the actions you have taken or are planning to take:
A maintenance check was completed on the 10/04/2019 and will be completed on a quarterly basis from now.

Proposed Timescale: 10/04/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Improvements were required in relation the the containment of potential fires, such as:
• cross corridor fire doors in both the old and new wings required review to ensure they provided an effective barrier against the spread of smoke and flames in the event of a fire
• bedroom doors were held open using furniture such as chairs and bedside tables

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

Please state the actions you have taken or are planning to take:
• Cross fire doors completed
• All staff have been informed not to hold bedroom doors open with furniture

Proposed Timescale: 18/04/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
There were two separate fire alarm systems in the centre, one which covered the older section of the premises and the second covered the new wing. The provider was requested to review these systems to ensure they adequately detect, contain and give warning of fires throughout the centre.

8. Action Required:
Under Regulation 28(2)(ii) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
Both fire alarm systems have now been merged together

Proposed Timescale: 09/05/2019

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 review of records and discussions with the person in charge indicated that not all incidents requiring notification to the Office of The Chief Inspector were submitted within the required time frame.

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

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

In this case we had not sent in the appropriate notification form as it was still being investigated but has since been sent in. In the future we will notify HIQA on time.

Proposed Timescale: 16/04/2019