

**Health Information and Quality Authority  
Regulation Directorate**

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



|   |  |
|---|--|
| <b>Centre name:</b>                                       | Ashborough Lodge Nursing Home                            |
| <b>Centre ID:</b>   | OSV-0000194  |
| <b>Centre address:</b>                                    | Lyre Road,<br>Milltown,<br>Kerry.                        |
| <b>Telephone number:</b>                                  | 066 976 5100   |
| <b>Email address:</b>                                     | nursemanager@allenfield.ie                               |
| <b>Type of centre:</b>                                    | A Nursing Home as per Health (Nursing Homes)<br>Act 1990 |
| <b>Registered provider:</b>                               | Allenfield Care Homes Limited                            |
| <b>Provider Nominee:</b>                                  | Bernt Kristian Krabberod                                 |
| <b>Lead inspector:</b>                                    | Mary O'Mahony  |
| <b>Support inspector(s):</b>                              | Mairead Harrington                                       |
| <b>Type of inspection</b>                                 | Unannounced  |
| <b>Number of residents on the<br/>date of inspection:</b> | 58   |
| <b>Number of vacancies on the<br/>date of inspection:</b> | 0  |

## **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.

**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 Quality Standards for Residential Care Settings for Older People in Ireland.**

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

**The inspection took place over the following dates and times**

From: 27 January 2016 11:15 To: 27 January 2016 19:00

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

| <b>Outcome</b>  | <b>Our Judgment</b>      |
|---|--------------------------|
| Outcome 02: Governance and Management                       | Substantially Compliant  |
| Outcome 04: Suitable Person in Charge                       | Compliant                |
| Outcome 05: Documentation to be kept at a designated centre | Substantially Compliant  |
| Outcome 07: Safeguarding and Safety                         | Substantially Compliant  |
| Outcome 08: Health and Safety and Risk Management           | Substantially Compliant  |
| Outcome 09: Medication Management                           | Substantially Compliant  |
| Outcome 10: Notification of Incidents                       | Non Compliant - Moderate |
| Outcome 11: Health and Social Care Needs                    | Substantially Compliant  |
| Outcome 13: Complaints procedures                           | Substantially Compliant  |
| Outcome 18: Suitable Staffing                               | Compliant                |

**Summary of findings from this inspection**

The purpose of this inspection of Ashborough Lodge Nursing Home by the Health Information and Quality Authority (HIQA or the Authority) was to monitor ongoing regulatory compliance. The centre was located in a rural setting and was modern and purpose built. As part of the inspection process inspectors met with residents, relatives, the person in charge, the clinical nurse manager (CNM), nursing staff, care staff, catering staff and household staff. Inspectors observed practices and reviewed documentation such as care plans, medical records, staff files, the risk register and fire safety records. A sample of relevant policies was reviewed.

The person in charge and the provider had attended to the actions required from the previous inspection. Inspectors found the premises, fittings and equipment were of a high standard. There was a good standard of décor in the centre and it was a bright and spacious building. Inspectors observed that residents had access to clothes washing facilities in the bedrooms and there were personal fridges in each bedroom also.

The person in charge was involved in the centre on a daily basis and was found to be easily accessible to residents, relatives and staff. There was evidence of individual resident's needs being met and staff supported residents in maintaining their independence where possible. Community and family involvement was encouraged and visitors were seen to be plentiful throughout the day . There was an activities programme and an advocacy service available for residents.

Some actions were required to comply 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. These improvements included: health and safety, safeguarding and safety, risk assessment and staff training.

**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 Quality Standards for Residential Care Settings for Older People in Ireland.**

***Outcome 02: Governance and Management***

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

**Theme:**

Governance, Leadership and Management

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

No actions were required from the previous inspection.

**Findings:**

The person in charge was available throughout the inspection. She was supported by an experienced clinical nurse manager (CNM). There were clear lines of authority and accountability. There were daily handover meetings and all grades of staff were included in these meetings. The system to manage, audit and document risk was robust.

Inspectors saw evidence of staff meetings and observed that issues were addressed accordingly. There was evidence of consultation with residents and relatives in the minutes of residents' meetings.

The provider lived abroad. However, he had employed a consultant to visit the centre on his behalf on a monthly basis. The person in charge stated that resources for residents and staff were accessible and readily available. Inspectors observed that issues identified as requiring attention on the previous inspection had been addressed.

The person in charge stated that she was in telephone contact with the provider and that he visited the centre last year. Inspectors spoke with the aforementioned consultant following the inspection. He stated that he would arrange for monthly phone contact between the person in charge and the provider to enhance communication and to fulfil regulatory requirements.

**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:**

The person in charge was a registered nurse with the required experience and knowledge in older adult care. She was engaged in the governance and operational management of the centre on a daily basis. Staff with whom inspectors spoke had a clear understanding of the management and reporting structure in the centre. They confirmed that the person in charge was approachable and dynamic.

The person in charge was engaged in continuous professional development. She informed inspectors that she attended conferences and relevant courses. During the inspection she demonstrated adequate knowledge of Regulations and Standards for the sector.

Inspectors viewed comprehensive audits completed by the person in charge and she had also undertaken a detailed yearly review on the safety and quality of care in the centre on behalf of the provider. This was reviewed by inspectors.

**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):**

No actions were required from the previous inspection.

**Findings:**

On this inspection this Outcome was addressed only in so far as it relates to the documentation required to be maintained for staff in the centre. In a sample of staff files reviewed inspectors found that the centre had not acquired Garda vetting for one

staff member. While Garda vetting was available for the staff member it had been transferred from the previous employer.

**Judgment:**

Substantially Compliant

***Outcome 07: Safeguarding and Safety***

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

**Theme:**

Safe care and support

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

No actions were required from the previous inspection.

**Findings:**

There was a policy on, and procedures in place for, the prevention, detection and response to abuse dated December 2013. However, this policy did not identify and define the different types of abuse such as neglect or emotional and physical abuse. It also required review to reflect the development of the current national policy on safeguarding vulnerable adults which came into effect in December 2014. This was addressed by the person in charge following the inspection.

The training matrix indicated that all staff had received up-to-date training in protection and those staff members spoken with had received training, understood how to recognise instances of abuse and were aware of the appropriate reporting systems in place. However, a review of records indicated that a potential abuse allegation had been recorded as a complaint and had not been notified appropriately in keeping with statutory requirements. Action in this regard was recorded under Outcome 10: Notifications. Residents spoken with stated they felt safe and well supported in the centre. They were clear on who was in charge and who they could go to should they have any concerns they wished to raise.

There were closed circuit television (CCTV) cameras at a number of locations in the public areas of the centre. Inspectors observed that there were signs indicating the use of CCTV cameras and there was a relevant policy in place. Residents' privacy was respected and all residents had private bedrooms with en suite facilities.

A policy and procedure was in place in relation to managing behaviour that challenges. This had been reviewed in January 2016. Staff spoken with demonstrated the appropriate skills and knowledge to respond to, and manage, behaviour that might present as challenging. A restraint policy was in place dated March 2012. However, this had not been reviewed within the required three year framework. However, an updated

copy of the policy was forwarded to the Authority following the inspection. Where restraints were in use appropriate risk assessments had been undertaken. Care plans reviewed by the inspector, where bed-rails were in use for example, contained documented assessments and consent forms. Nursing notes reflected regular monitoring and review of restraints in accordance with standard requirements.

A policy on personal property and finance was in place and a record of residents' belongings was maintained on individual care plans. Systems of recording transactions included a receipt log and double signatures. Audit of finance processes were undertaken and where actions were identified these were recorded as part of the quality review.

**Judgment:**

Substantially 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):**

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

**Findings:**

The centre had an updated health and safety statement in place. The risk register contained risk assessments of all areas in the centre and the health and safety committee reviewed this monthly, or as required. Inspectors noted that service records for equipment were available. Staff with whom inspectors spoke stated that they had received manual handling training and training records confirmed this. Staff were also observed assisting residents to mobilise safely.

Inspectors viewed fire safety training records for staff. Staff with whom inspectors spoke confirmed their understanding of what to do in the event of a fire. Fire alarm testing was conducted regularly and service records in relation to fire extinguishers were seen to be in order. Daily fire door and fire panel checks were undertaken according to documentation seen by inspectors. Instructions on what to do in the event of a fire were prominently displayed. There was an emergency plan in place and this contained details of a safe place for residents to be accommodated in the event that evacuation of the centre was necessary.

Records of food safety training for nurses and care staff were viewed by inspectors. Risk assessments were in place for the use microwaves, fridges and washing machines in individual bedrooms. Inspectors observed that the environment was kept clean and well maintained. Adequate supplies of personal protective equipment were available for staff. Alcohol hand gel dispensers were located around the centre and staff were observed



using this appropriately. Inspectors observed that there were measures in place to control and prevent infection including training. Staff with whom inspectors spoke demonstrated knowledge of infection control practices. Alginate bags were readily accessible for soiled linen.

The floor covering had been replaced in a number of rooms since the previous inspection and ceiling repairs had been undertaken. There was a full time maintenance person in the centre. He informed inspectors that the internal areas were due to be painted this year and he outlined the other internal and external duties for which he was responsible. He stated that the emergency lighting system was being upgraded this year. Inspectors found that he had been afforded relevant training. The front entrance door had been secured since the previous inspection and a keypad lock had been installed on the door to the large activity room on the right side of the entrance. The large windows in this room had been fitted with appropriate restrictors, following a risk assessment.

However, inspectors noted that appropriate signage was not in place for the storage of oxygen cylinders in three areas in the centre. This was significant as inspectors were informed that a number of residents liked to smoke in the designated smoking room in the centre. Appropriate signage was put in place while inspectors were on the premises.

**Judgment:**

Substantially Compliant

***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:**

There was a centre-specific medication policy with procedures for safe ordering, prescribing, storing and administration of medicines. The person in charge conducted monthly medication audits. Nursing staff, with whom inspectors spoke, demonstrated an understanding the medication management policy. Residents had photographic identification in place on their medication administration record. There was a specific fridge in place for the storage of medications and the fridge temperature was monitored and recorded.

Controlled drugs were stored in line with An Bord Altranais agus Cnaimhseachais na hEireann Guidelines 2007. Stock levels of medication were checked at the end of each shift by two nurses. Inspectors noted that expiry dates and stock levels of controlled drugs checked were in order. During the inspection, inspectors noted that in line with

best practice guidelines two nurses checked and signed controlled drugs, before administration to a resident.

Medications which were discontinued were signed by the GP. Drugs prescribed as PRN (when necessary) had the maximum dose in 24 hours recorded. Inspectors noted however, that a small number of medications administered had not been signed by the administering nurse.

**Judgment:**

Substantially Compliant

***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:**

Notifications of specified events had been received by the Authority in line with regulatory requirements. However, inspectors found that an incident of an alleged abusive interaction had been recorded and investigated as a complaint and not been notified to the Authority, as required under Schedule 4, section 7 (h) of the Regulations. This notification was received following the inspection.

**Judgment:**

Non Compliant - Moderate

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

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

**Theme:**

Effective care and support

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

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

**Findings:**

There was evidence that residents' health care needs were met through timely access to the GP service. Residents were facilitated to retain their own GP, if they expressed a preference for this. Care plans were individualised and risk assessment tools were used to assess residents' needs. Restraint assessments for the use of bed rails and consent for this were seen in a sample of care plans reviewed. A daily nursing and health care assistants' narrative note was documented. Inspectors saw evidence that residents were involved in formulating their care plans. The person in charge informed inspectors that residents could access personal information, if requested.

There was evidence of access to the multidisciplinary team. Optical and dental services were accessible. A chiropodist visited regularly. Speech and language services were available. Dietary advice was received from a dietician from a nutritional company. Training for staff on nutritional aspects was also facilitated by this service. The hairdresser visited as required and residents informed inspectors that they enjoyed this service.

Residents had opportunity to attend the religious service of their choice. During the inspection residents were engaged in activities in the sitting room. There was evidence of reminiscence opportunities. Residents informed inspectors that they enjoyed having a choice of activities. According to the person in charge, the activities co-ordinator also met residents on a one-to-one basis if they did not wish to partake in group activities. One resident was the chairperson of the residents' committee. However, the person in charge informed inspectors that this resident had been ill in recent months. She stated that meetings with this resident would resume in the near future. Inspectors spoke with residents who expressed that their choice of attendance or not at activities was respected. Residents were seen to be walking around the premises independently and sometimes accompanied by a staff member. Evidence of life-story work was viewed by inspectors and residents had personal photographs of relatives displayed in their rooms. Inspectors observed that residents had signed consent for their photographs to be used for identity purposes.

There were a number of suitable activities available for residents. However, these were confined to one hour daily. In addition, for residents who had been diagnosed with dementia, activities were limited. There was a dementia specific unit in the centre, however the environment in this area was not conducive to wellbeing in dementia. There was a limited choice of meaningful activities available for these residents. A number of residents were seen to be sitting at empty tables even though there were two staff assigned to the sitting room at that time. Staff spoken with by inspectors stated that some residents had returned from a walk. While bedrooms in this area were seen to be personalised this did not extend to the main communal rooms in the dementia specific area. The person in charge informed inspectors that suitable DVDs and music CDs were available in the main activity room which was located elsewhere in the centre.

**Judgment:**

Substantially Compliant

**Outcome 13: Complaints procedures**

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

**Theme:**

Person-centred care and support

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

No actions were required from the previous inspection.

**Findings:**

A written operational policy for the management of both verbal and written complaints was in place dated March 2014. The procedure for making a complaint, including the necessary details of a nominated complaints officer, was displayed at the entrance area of the centre. The procedure outlined an appeals process that provided contact information for the wider appeals process including the office of the Ombudsman.

Complaints were recorded on a form and a log was maintained. The form provided a space to enter information about the outcome and whether the issue was resolved to the satisfaction of the complainant. However, in one instance this information had not been completed. Records indicated that any issues raised were dealt with promptly at an early stage.

**Judgment:**

Substantially 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):**

No actions were required from the previous inspection.

**Findings:**

Residents and relatives indicated that staff were responsive to their needs and treated them with respect and dignity. Centre-specific, evidence-based recruitment policies and

procedures were reviewed by inspectors. Staff records indicated that staff were recruited and inducted in accordance with these policies.

On the morning of inspection, there were four nurses on duty, in addition to the person in charge, eleven care staff, three catering staff and two housekeeping staff. Staffing levels decreased in the afternoon and evening and staffing levels were based on residents' needs. There were named staff members caring for each resident and this information was displayed in the bedrooms.

Inspectors reviewed staffing rotas, staffing levels and skill mix. The person in charge informed inspectors that that she was satisfied that there were sufficient staff on duty to meet the needs of residents. Inspectors found that appropriate training was provided to staff and they were supported to deliver care that reflected contemporary evidence based practice. Staff had completed mandatory fire safety and fire evacuation training, elder abuse training and training in manual handling. The person in charge explained that a number of staff nurses provided in house training. Registration details for nursing staff were seen by inspectors.

Staff changing rooms and facilities were provided. Inspectors looked at a sample of staff files and found that they contained the regulatory information required under Schedule 2 of the Health Act 2007 (Care and Welfare Regulations in Designated Centres for Older People) Regulations 2013. However, Garda vetting had not been sought by the centre, for one carer. This was addressed under Outcome 5: Documentation.

**Judgment:**

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:***

Mary O'Mahony  
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<sup>1</sup>

|                            |                               |
|----------------------------|-------------------------------|
| <b>Centre name:</b>        | Ashborough Lodge Nursing Home |
| <b>Centre ID:</b>          | OSV-0000194                   |
| <b>Date of inspection:</b> | 27/01/2016                    |
| <b>Date of response:</b>   | 26/02/2016                    |

### Requirements

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

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

### Outcome 02: Governance and Management

#### Theme:

Governance, Leadership and Management

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

The registered provider was required to ensure that the requirements of the Regulations were fulfilled by engaging in the governance and management of the centre on a regular basis.

#### 1. Action Required:

Under Regulation 23(b) you are required to: Put in place a clearly defined management

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

structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

Registered provider and Consultant will have a conference call once a month with the person in charge.

**Proposed Timescale:** 26/02/2016

**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:**

Garda vetting had yet to be obtained for one staff member. The Garda vetting in place related to a previous place of employment.

**2. 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:**

Garda vetting for this centre was applied for on 29/01/16 for this employee.

**Proposed Timescale:** 29/03/2016

**Outcome 07: Safeguarding and Safety**

**Theme:**

Safe care and support

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

The policy on restraint was required to be updated to ensure that national guidelines and best practice was implemented in the centre.

**3. Action Required:**

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

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

All the policies and procedures in Ashborough Lodge have been updated last January 2016 including Restraints Policy.

**Proposed Timescale:** 26/02/2016

**Theme:**

Safe care and support

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

The policy on the prevention of abuse required updated to include all types of abuse and to reference the new national policy on Safeguarding Vulnerable Adults. The policy in the centre was used to guide staff training in the recognition and prevention of elder abuse.

**4. Action Required:**

Under Regulation 08(2) you are required to: Ensure staff are trained in the detection and prevention of and responses to abuse.

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

Policy on Safeguarding vulnerable persons at risk of abuse has been updated now based on the HSE National Policy and Procedures which came into effect in December 2014. The updated policy reflect and define the different types of abuse such as physical, sexual, psychological, financial or material, neglect and acts of omission and discriminatory abuse.

**Proposed Timescale:** 26/02/2016

**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 centre had oxygen cylinders on the premises. This had not been risk assessed and appropriate signage had not been put in place.

**5. Action Required:**

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

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

Appropriate signage is now in place on those rooms where we store oxygen cylinders.

**Proposed Timescale:** 26/02/2016



## Outcome 09: Medication Management

### Theme:

Safe care and support

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

Not all medications administered had been signed by the administering nurse.

### 6. Action Required:

Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

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

Nurses are more aware of importance of signing in the Medication Administration Record following administrations of prescribed medicines to the Residents.

**Proposed Timescale:** 26/02/2016

## 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 person in charge had not given notice to the Chief Inspector within three working days of an incident of an alleged abusive interaction.

### 7. 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:

Complaints had been dealt with as per Ashborough Lodge complaints policy and procedures.

Ashborough Lodge took on board the importance of notifying HIQA within three working days of an incident of an alleged abuse.

**Proposed Timescale:** 26/02/2016

## Outcome 11: Health and Social Care Needs

### Theme:

Effective care and support

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

Inspectors were not assured that the needs of residents were being adequately met in the dementia specific unit. Meaningful activities and opportunities for useful occupation had not been made available for residents, who had diverse and interesting backgrounds and life stories.

### 8. Action Required:

Under Regulation 05(1) you are required to: Arrange to meet the needs of each resident when these have been assessed in accordance with Regulation 5(2).

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

Activity coordinators and all staff of Ashborough Lodge are aware of the report, will update activities in the Dementia unit and will ensure to adhere to it. A 101 list of activities is in place now from the Alzheimer's Society of Ireland and UK. Ashborough Lodge will discuss and take into account any suggestions from our residents, family and staff members on our next meeting.

**Proposed Timescale:** 30/06/2016

## Outcome 13: Complaints procedures

### Theme:

Person-centred care and support

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

In a sample of records viewed by inspectors documentation had not been completed, in one instance, of the outcome of a complaint and of whether or not the complainant was satisfied had not been recorded..

### 9. Action Required:

Under Regulation 34(1)(g) you are required to: Inform the complainant promptly of the outcome of their complaint and details of the appeals process.

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

Complaints procedure has been up-dated and reviewed and all staff are aware of this changes. All outcomes and feedback whether satisfactory or not by the involved parties will be documented in the report and logged in to the complaints book.

**Proposed Timescale:** 26/02/2016

