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:	New Lodge Nursing Home
Centre ID:	OSV-0000073
Centre address:	Stocking Lane, Rathfarnham, Dublin 16.
Telephone number:	01 495 0021
Email address:	info@bloomfield.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Bloomfield Care Centre Limited
Provider Nominee:	Damien O'Dowd
Lead inspector:	Deirdre Byrne
Support inspector(s):	Shane Walsh
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	36
Number of vacancies on the date of inspection:	0

About Dementia Care Thematic Inspections

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

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

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

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
06 October 2016 07:30	06 October 2016 18:00

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate	Substantially Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Substantially Compliant
Outcome 05: Suitable Staffing	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Major
Outcome 08: Governance and Management		Non Compliant - Major

Summary of findings from this inspection

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

Inspectors found areas of risk that required immediate action to be taken. There were deficits the provision of An Garda Siochana Vetting for some staff and volunteers. Staff knowledge of fire evacuation procedures also required improvement. These issues were discussed with the provider who was required to take immediate action during the inspection.

Inspectors met with residents and staff members. They also met the person nominated on behalf of the provider (the provider) and the acting person in charge. Inspectors tracked the journey of residents with dementia, and observed the care practices and interactions between staff and residents. They reviewed documentation such as care plans, medical records and staff files.

The provider had completed the self-assessment and compared the service with the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and the National Standards for Residential Care Settings for Older People in Ireland. The provider's self assessment gave a compliance rating, including some moderate non compliance ratings.

On the day of the inspection there were 36 residents accommodated in the centre. The person in charge, in the self assessment, estimated that 22 residents had a dementia diagnosis. There is no dementia specific unit and residents with a dementia are accommodated throughout the centre. There was good access to medical care however, deficits were identified in the completion of care plans. There were adequate staff number and skill mix to meet residents' assessed healthcare needs, however supervision of staff required improvement.

The premises were generally well-maintained, spacious and clean but it required improvement to ensure the design promotes the independence and wellbeing of residents with a dementia.

Inspectors found that residents had a choice of interesting things to do during the day. However, improvements were required to ensure there were meaningful interactions between staff and residents. The management style of the centre maximized residents' capacity to exercise personal autonomy and choice.

The following outcomes were reviewed as part of the inspection, and the level of compliance is recorded below:

- Health and Social Care Needs : moderate non-compliance
- Safeguarding and Safety: major non-compliance
- Residents' Rights, Dignity and Consultation: substantially compliant
- Complaints procedures: substantially compliant
- Suitable Staffing: moderate non-compliance
- Safe and Suitable Premises: compliant
- Health Safety and Risk Management - major non-compliance
- Governance and Management: major non-compliance

There were 17 actions required following this inspection. Ten of the actions are the responsibility of the provider and seven the responsibility of the person in charge.

These are included in the findings of the body of the report and the action plan at the end of the report.

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 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:
Inspectors found the documentation of residents' assessed health care needs required improvement. The supervision at mealtimes and an aspect of medicine management also required improvement.

Residents' were assessed on admission to the centre and clinical assessments were completed for a range of healthcare needs. However, the completion of some assessments required improvement. For example, one admission assessment read was incomplete with no information on the resident. One resident's assessments were completed when they were not in the nursing home and a patient in hospital.

Inspectors found care plans were developed for residents' health care needs. However, the completion and review of care plans required improvement:
- some care plans did not guide the care to be delivered to residents. For example, falls prevention, enteral feeding, end-of-life care and management of responsive behaviours.
- some care plans were not formally reviewed on four monthly basis or as residents' needs changed.
- The recommendations of some allied health professionals were not consistently incorporated into some care plans e.g. dieticians prescribed feeding treatment.
- There was inconsistent evidence of consultation with residents, or their next of kin, in their of care plans.

These matters were discussed with the acting person in charge during the inspection. While audits of care plans were carried out there were no written reports available for inspectors to review.

The practices in place to prevent falls required improvement.Two residents who had experienced falls resulting in a serious injury were tracked. Their care plans were not updated to include the actions to prevent more falls occurring. There were neurological observations completed for an un-witnessed fall or a suspected head injury. An accident/incident form was completed. It was noted there was review of the incident forms or indication of any follow up action taken. This is discussed in Outcome 8 (health

and safety).

There were policies and procedures were in place for the management of wound care. Staff were familiar with wound care procedures.

The residents had good access to GP (general practitioner) services. If residents wished they could retain their own GP and this was confirmed by residents. There was access to a range of allied health professionals. There was evidence of referrals and visits from services for example, dentist, optometry, occupational therapy, dietician and psychiatric services.

There were procedures in place if residents were transferred to hospital. A hospital transfer letter was sent to the hospital that outlined the residents assessed health care needs, prescribed medicines and any other pertinent information. It was noted there was no copy of the letters on file. Inspectors were shown a form that was populated prior to a resident's transfer to hospital. There were records of nursing and medical transfer letters sent from the acute hospital back to the centre.

Inspectors spent time in the dining room during the lunchtime meal. Tables were pleasantly set and meals were served from a hot unit by a member of the catering staff. There was an adequate number of staff assisting residents at the meal, with a nurse and two healthcare assistants present. However, the supervision of mealtime required improvement. Inspectors observed one resident having difficulty eating from a table which was too high. No action was taken until this was brought to staff attention. Another resident told staff she did not like the meal she was given. The resident was told to put the meal aside and have it later- no alternative was offered to the resident. A menu was displayed in picture format however; its layout did not inform residents clearly what was on the menu (See Outcome 6- premises).

Residents who required meals and drinks prepared to a certain consistency had them served as reflected in their assessment. There was good choice for residents including residents prescribed a modified textured diet.

Residents each had a malnutrition risk screening tool (MUST) completed on admission and this was reviewed on a monthly basis. Residents were weighed and had their body mass index (BMI) completed on a monthly basis. Where residents had refused to have their weight taken this was respected and documented. Those with nutritional needs had a care plan in place. Inspectors saw that residents' likes, dislikes and special diets were also recorded.

There were medicine management policies in place to protect residents. However, an error was identified by inspectors during a review of residents' administration and prescription sheets. A resident prescribed a weekly pain medication was not administered the medicine although nursing staff had signed as having administered it. The medicine was not signed by two staff as required by professional guidelines. The acting person in charge was required to take immediate action. The inspector was later informed a GP would review the resident the next day and an investigation would be undertaken to address the matter.

The actions from the previous inspection regarding as required (PRN) medicines were found to be addressed. There was evidence of PRN medicines in stock. There was guidance on each prescription about when a PRN medicine should be used. There was evidence of regular review of medicines by the GP and the pharmacy service. The pharmacists contact details were also displayed in the centre. The pharmacist also visited residents and was in the centre on the inspection day.

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

Judgment:
Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
Inspectors found that improvement was required to ensure that residents were sufficiently safeguarded.

Two staff members did not have vetting appropriate to their role. In addition, several volunteers and outsourced service providers attended the centre and provided valuable social activities and services. Not all had been vetted appropriate to their role. In addition, their roles and responsibilities were not set out in writing as required by the regulations. The provider undertook to address this as a matter of urgency and put additional safeguarding measures in place until it was addressed.

Staff members spoken to were knowledgeable of what constitutes abuse and knew what to do in the event of an allegation, suspicion or disclosure of abuse. However, training records indicated 10 staff had not received up-to-date training in recognising and responding to abuse. This was brought the attention of the acting person in charge. Following the inspection, a schedule of planned training was submitted confirmed by the provider. Staff attendance sheets were submitted to HIQA after the training. Residents spoken to stated they felt safe living in the centre.

There was a policy on, and procedures in place for, the prevention, detection and response to abuse. There had been previous allegations of abuse notified to HIQA. The provider and the acting person in charge were familiar with the procedures to investigate allegations of abuse.

There was a policy on, and procedures in place, for managing responsive behaviour.

Where there was evidence of responsive behaviours, care plans were developed. Some care plans did not fully guide practice. See Outcome 11 (healthcare needs).

Inspectors found a restraint free environment was promoted in the centre. The main form of restraint was bedrails, and small number of residents required lap-belts and alarms where they were deemed a risk of leaving the centre. There were risk assessments completed, and safety checks while restraint was in place. However, assessments were not completed for the use of the alarms. Staff spoken with confirmed the various alternatives that had been tried prior to the use of bedrails. Additional equipment such as low beds had also been purchased to reduce the need for bedrails. Two hourly checks were completed when in use. Care requirements were detailed in the care plans.

There was little use of “as required” (PRN) medicine to manage responsive behaviours. Where these medicines had been administered it was in very specific circumstances, and systems were in place to clearly record what alternative measures had been considered in advance.

This outcome was judged to be substantially compliant in the self-assessment, and inspectors judged it as major non compliant.

Judgment:
Non Compliant - Major

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:
Inspectors found residents were consulted with in how the centre was organised and their rights were respected. There were improvements identified to ensure residents were engaged with in a meaningful way by staff.

Residents were consulted with about how the centre was run and organised. A residents’ forum met every few months and read minutes of the last two meetings. The meetings confirmed a range of matters were discussed. The meetings, which were facilitated by an independent advocate, included follow up action to any issues brought up by residents. One resident told inspectors he attended the meetings.

The acting person in charge outlined details of independent advocacy services available to the residents. Their contact details were displayed in the centre.

Residents' religious and civil rights were respected. There were mass and prayer services held on a regular basis for all religious denominations in the centre. The provider confirmed they had been offered the opportunity to vote each election. Residents could vote at the local polling station, or in the centre.

As part of the inspection, inspectors spent two periods of time observing staff interactions with residents with a dementia. The observations took place in the main sitting room of the centre. The first observation of the quality of interactions between residents and staff for selected periods of time indicated that 83% reflected task orientated care while 17% indicated neutral care. There were positive engagements with residents, however, most interactions were task-driven as residents were being served their breakfast. One staff member continuously engaged in a meaningful with individual residents throughout most of the observation. Other staff were observed in the room assisting residents, but there were minimal meaningful interactions observed.

The second observation of the quality interactions indicated 40% task orientated and 60% neutral care. An occupational therapist assistant ensured residents were engaged with. She moved between residents and encouraged them to get involved in a sing-song session taking place. It was also observed that some individual residents unable to take part in the singing sat for long periods of time with no staff interaction. Two staff had a conversation over a resident who was sitting beside them. These results were discussed with the acting person in charge at the feedback meeting and possible areas for improvement were discussed.

Inspectors found the management style of the centre maximised residents' capacity to exercise personal autonomy and choice. Residents were observed to leave the centre independently and access other parts of the campus where the centre was located. These areas included a large canteen, meeting rooms, sitting areas, enclosed gardens. Inspectors were told that there were groups which residents could also attend. A ''men's shed'' group also met weekly. One resident enjoyed going into the garden and was later observed in the green house. Staff told inspectors residents were free to plan their own day, to join in an activity or to spend quiet time in their room. Staff told the inspector that mealtimes were at the residents choosing and they could eat in the dining room, main canteen or their own bedroom.

Newspapers and magazines were available and the inspectors saw some residents reading these. There was a varied activities programme with arts and crafts, exercise, bingo, and music included. The occupational therapist assisted facilitated activities in the centre five days a week. An activity programme was displayed on a notice board in a pictorial format.

This outcome was judged to be moderate non compliant in the self-assessment, and inspectors judged it as substantially compliant.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

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

Findings:
A complaints procedure was in place that explained how to make a complaint. However, some improvements were needed around documenting if complainants had been informed of the outcome of a complaint.

There was a complaint's policy in place that guided practice. The policy outlined the steps to be taken relating to both local and verbal complaints and formal or written complaints. The person in charge was the person nominated to deal with all complaints and ensure that they are fully investigated. There was an appeals process outlined within the policy. Residents informed the inspectors that if they had a complaint that they would speak to a nurse.

The complaints procedure was displayed prominently in an area near the nurses' station and was in line with the information within the complaints policy..

Inspectors reviewed complaints records. Verbal complaints were recorded in a complaints log and contained information of the complaint, the action taken to address the complaint, the outcome of the complaint and if the complaint was open or closed. However, the records did not consistently detail if the complainant had been informed of the outcome of the complaint.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
An appropriate staff numbers and skill mix to meet the assessed needs of the residents. However, the recruitment process, planning of staff training and supervision of staff supervision required improvement.

The action from the previous inspection regarding staffing levels was addressed. Since then, two additional healthcare assistant shifts had been added to the roster to ensure residents' assessed needs in the evening were addressed. It was noted that agency staff were regularly used to fill vacant staff posts. However, the provider was in the process of recruiting staff to fill these positions. A service level agreement was in place that confirmed agency staff had the required information, Garda Siochana vetting and mandatory training as per the regulations. However, induction process for agency staff required improvement as discussed in Outcome 7 (Health Safety and Risk Management).

There was a planned and actual roster available which confirmed staffing levels reflected those on the inspection day.

Training records in the centre were not accurately maintained and it was not clear if staff had up-to-date training. Inspectors reviewed the training records and gaps in refresher training were identified in- fire safety, (as discussed in Outcome 7), protection against elder abuse (discussed in Outcome 2 Safeguarding and Safety), and movement and handling.

Recruitment procedures had not ensured all staff and volunteers in the centre had evidence of Garda Siochana vetting. Inspectors reviewed nine staff files and found vetting was not in place for two staff members. This is discussed under Outcome 2. Volunteer files were also reviewed. However, not all volunteers had been Garda vetted. See outcome 2 for more details.

Inspectors read records of staff supervision meetings. The meetings took place between once and twice a year. However, the supervision of staff required improvement as evidenced in Outcome 1 and Outcome 7.

Judgment:
Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

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

Findings:
The design and layout of the premises was in line with regulations. The centre was purpose built and laid out over one floor.

The centre consisted of three corridors that met at the nurses' station. It was clean and well maintained, well lit from both artificial and natural lighting. Corridors were wide for easy movement of residents with hand rails on both sides.

Further consideration in terms of best practice in design for dementia care of some aspects of the premises was found, for example,:
• use pictorial signs or lettering on bedroom doors.
• the use of contrasting colour and signage to assist navigation for those in communal corridors.
• Procedures to guide residents in an accessible format for example, the menu, complaints process.

There were 32 single bedrooms and two twin bedrooms in the centre. Each room had an ensuite shower and toilet. Inspectors were given permission to enter four residents' bedrooms. The residents told inspectors they were happy with their bedroom and the privacy it afforded them. The bedrooms were spacious, with room for personal belongings and were decorated in accordance with resident's wishes. Call bells were provided in residents' bedrooms and communal areas. There were adequate numbers of toilets and showers to meet the resident's needs. Toilets and showers had grab rails and shower seats for those who required them.

The living room was well decorated with homely furniture. Residents' photos and paintings were displayed throughout this room also with good colour contrast between the walls, flooring and furniture. There was a quiet room within the centre which was also decorated in a homely manner however, on the day of inspection this was not available for residents' as it was used to store beds and equipment. This was brought to the attention of the provider and the equipment was immediately removed.

Residents had direct access to a secure garden area from the living room. There also was a sheltered smoking area in the garden for residents' use.

Judgment:
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:
The systems in place to ensure staff were knowledgeable of the centre's fire evacuation procedures require improvement. Inspectors identified areas of risk that required immediate attention: inspectors spoke to a number of staff who were not familiar with the procedures to be followed in the event of a fire. While there were fire procedures prominently displayed in the centre, these did not guide staff practice. There were detailed procedures located within the fire safety management policy, but staff were not

aware of them.

Inspectors were told staff knowledge was assessed through a weekly fire test. However, the tests did not adequately assess staff knowledge of the fire evacuation procedures and there was no record of it maintained. Therefore, it was not clear how long each drill took, the staff in attendance, outcome and improvements to be brought about.

Fire safety training records read indicated three staff had not completed refresher training in over a year. Furthermore, there was no fire safety induction for agency staff new to the centre, some of whom were also unclear of the procedures.

These matters were brought to the attention of the provider who was required to take immediate action to address them. During the inspection provider outlined the following action that would be taken:

1. Provision of fire safety training for staff on the 13 October 2016
2. Revised fire safety procedures to be displayed at the nurses' station,
3. Staff, including agency, were to be briefed on fire safety precautions at start of duty,
4. Fire drills to be revised and recorded for learning purposes.

Following the inspection the provider submitted staff attendance records for the fire safety training carried out.

There were arrangements in place to maintain fire equipment. Records indicated that fire extinguishers in the centre were being serviced annually and had been serviced in 2016. Records of service of fire alarms and emergency lighting service records were also read. Emergency lighting services was being upgraded.
There was a risk management policy in place that met the requirements of the regulations. However, inspectors identified two areas of risk in the centre:

1. The storage of oxygen cylinders in the treatment room was not secure.This was brought to the attention of staff who took action.
2. Access to unsecured parts of the garden from bedrooms by residents at risk of wandering.

Records reviewed showed incidents of accidents documented. However, the individual incidents reports did not consistently demonstrate the actions which had been taken following an accident. For example, where residents had falls resulting in serious injuries.

Judgment:
Non Compliant - Major

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

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

Findings:
Inspectors found there was insufficient governance to ensure the effective delivery of care to residents in the centre. Furthermore, the systems in place to review the quality and safety of care provided to residents in the centre required improvement.

The centre is operated by Bloomfield Care Centre Limited. There was a clearly defined management team which included a board of directors, a chief executive officer who was also the provider. The provider had delegated responsibility for the day to day operation of the centre. A person in charge oversaw this. The person in charge reported to the provider who was also based full-time in the centre. On the day of the inspection an acting person in charge was deputising in the centre.

The systems in place to ensure the service provided to residents were effectively monitored required improvement. The governance and management systems did not ensure the quality and safety of care provided to residents was appropriately and consistently monitored to enable compliance with the regulations as supported in findings of this inspection. This was evidenced primarily in Outcome 7 and Outcome 8. Furthermore, areas of improvement were also found in Outcome 1 and Outcome 5. As reported earlier, the provider submitted an action plan after the inspection that outlined the improvements they would bring about to come into compliance.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Deirdre Byrne
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:	New Lodge Nursing Home
Centre ID:	OSV-0000073
Date of inspection:	06/10/2016
Date of response:	28/10/2016

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 01: Health and Social Care Needs

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A comprehensive assessments was not completed on one resident's admission.

The completion of assessments of residents requires improvement as outlined in the report.

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 05(2) you are required to: Arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to the designated centre.

Please state the actions you have taken or are planning to take:
The assessment of the resident identified on the day of inspection has been completed. A system of auditing the completion of assessments will be put in place from mid-November with the first cycle due to be completed within six weeks. This will then continue as a rolling audit.

Proposed Timescale: Commence audit week of 14 November 2016

Proposed Timescale: 14/11/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Care plans were not fully guiding practice as outlined in the inspection report.

Some care plans were not updated after a change in residents circumstances or needs.

2. Action Required:
Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

Please state the actions you have taken or are planning to take:
A practice has been introduced that the Registered Nurse assigned to a number of residents is now responsible to ensure that the careplan is updated to reflect a change in a residents circumstances or needs outside of the routine careplan review.

Proposed Timescale: In place

Proposed Timescale: 28/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of consultation with residents or their representatives in their care plan review.

3. Action Required:
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

Please state the actions you have taken or are planning to take:
The resident is invited to attend the MDT & careplan review meetings as is their next of kin where possible/permitted. The careplan is reviewed and a record of the meeting is recorded in the residents notes. Where a resident is unable / declines to attend or their next of kin is unable to attend they are consulted were possible before the meeting and feedback is given afterwards. This was not always entered into the resident's notes. A system of ensuring that this record is entered into the resident's notes is now in place.

Proposed Timescale: In place.

Proposed Timescale: 28/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The practices in place for the prevention of falls requires improvement

The management of residents with a PEG feeding tube requires improvement

4. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
The Action Plan incorporated in the FRAT is now also reflected in the review of the resident's careplan.

A new system for referral to the Speech & Language Service has been put in place and the system for referral to dietetics has also been reviewed and streamlined.

Proposed Timescale: In place.

Proposed Timescale: 28/10/2016

Theme:

Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The system of staff supervision at mealtimes requires improvement.

5. Action Required:
Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

Please state the actions you have taken or are planning to take:
The identified supervision of the Dining Room by a Registered Nurse on a daily basis is now in place.

Proposed Timescale: In place

Proposed Timescale: 28/10/2016

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
A medicine was not administered in accordance with a resident's prescription.

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:
A meeting took place with the individual staff members regarding the above medication error.

Proposed Timescale: In place

Proposed Timescale: 28/10/2016

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:
Two staff had not been vetted prior to commencing work in the centre.

Volunteers had not been vetted appropriate to their role.

Volunteers' roles and responsibilities were not set out in writing.

7. Action Required:
Under Regulation 08(1) you are required to: Take all reasonable measures to protect residents from abuse.

Please state the actions you have taken or are planning to take:
All staff are now in receipt of Garda Vetting and all newly recruited staff will now only commence when Garda Vetting is in place.

A review of vetting of all Volunteers is currently underway and the provision of their roles & responsibilities in writing is currently being addressed.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Ten staff had not completed training in adult safeguarding.

8. 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:
All staff are now in receipt of training in adult safeguarding.

Proposed Timescale: In place.

Proposed Timescale: 28/10/2016

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The engagement with residents in a meaningful way requires improvement as during

inspection, on occasions, it was identified that there were minimal meaningful interactions observed and interactions were task-driven.

9. 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:
The engagement with residents in a meaningful way is currently being reviewed as part of the system of staff supervision. The current recruitment of staff to fill existing vacancies will assist greatly with engagement.

Proposed Timescale: 18/11/2016

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaint log did not consistantly detail if the complainant had been informed of the outcome of the complaint.

10. 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:
An interim amendment has been put in place that a record is retained on the verbal complaints book of the outcome of the complaint and that the complainant has been informed of this.

A revised complaints book, to be in place by 21 December 2016, will also reflect this.

Proposed Timescale: In place.

Proposed Timescale: 28/10/2016

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Staff supervision was not found to be adequate and required improvement.

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

Please state the actions you have taken or are planning to take:
A comprehensive review of the system of staff supervision is currently taking place and will be completed by 18 November 2017.

Proposed Timescale: 18/11/2016

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff training records were not adequately maintained.

12. 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:
Following a review of training, a new system of both planning and recording of training will be in place by the 30 November 2016.

Proposed Timescale: 30/11/2016

Outcome 07: 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:
Two areas of risk were identified by inspectors which had not been assessed: the storage of oxygen cylinders and access to an unsecured part of the garden.

13. 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:
All oxygen cylinders are stored in the treatment room when not in use. The issue was

highlighted in the Drugs & Therapeutics Committee meeting on 27 September 2016 and it was agreed that all Oxygen cylinders in the building are to be on the appropriate trolley or removed from the building. This is now in place.

The access to an unsecured part of the garden is currently being assessed and will be completed by the 30 November 2016. Immediate steps have been taken to secure any exit points.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The completion and review of accidents in the centre that result in serious injury to residents requires improvement.

14. Action Required:
Under Regulation 26(1)(d) you are required to: Ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
A review of the documentation of follow up on Incident Reports has taken place and documentary evidence will be also included on the Incident Report where serious incidents or adverse events occur.

Proposed Timescale: In place

Proposed Timescale: 28/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Three staff had not completed refresher training in fire prevention.

15. 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:
The two of the three staff have received updated fire training and the third will receive training on return from leave.

Following a review of training, a new system of both planning and recording training will be in place by the 30 November 2016.

Proposed Timescale: 30/11/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not knowledgeable of the procedures to be followed in the event of a fire.

There was no fire safety induction for agency staff working in the centre.

The systems in place to ensure staff were knowledgeable of the fire evacuation procedures required improvement.

16. 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:
All staff currently rostered have received re-training in the procedures to follow in the event of a fire. A clearly identifiable local procedure has been drafted and implemented.

All agency staff now receive a documented induction on Fire Evacuation.

Proposed Timescale: 28/10/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was only some evidence of servicing of the fire alarm on a three monthly basis.

17. 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 programme to maintain all fire equipment, means of escape, building fabric and building services is in place. Following the upgrading of the Emergency Lighting this year which is now completed since mid-October the system for testing as per regulatory requirement is now in place.

Proposed Timescale: 24/10/2016

Outcome 08: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in the centre did not ensure the quality and safety of care provided to residents was consistently and effectively monitored and required improvement.

18. Action Required:
Under Regulation 23(c) you are required to: Put in place management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The current management systems are under review and will be completed by 18 November 2016.

Proposed Timescale: 18/11/2016