<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Swords Nursing Home</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000181</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Mount Ambrose, Swords, Co. Dublin.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>01 890 0089</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:swordsnursinghome@mowlamhealthcare.com">swordsnursinghome@mowlamhealthcare.com</a></td>
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<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
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<tr>
<td>Registered provider:</td>
<td>Mowlam Healthcare Services Unlimited Company</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Sheila McKevitt</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>Deirdre O'Hara</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>41</td>
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<td>Number of vacancies on the date of inspection:</td>
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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

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Major</td>
</tr>
<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
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</tr>
<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Non Compliant - Major</td>
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<tr>
<td>Outcome 08: Governance and Management</td>
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<td>Non Compliant - Major</td>
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Summary of findings from this inspection

This report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care in the centre. A change of management had taken place in April 2019. The centre's person in charge (director of nursing) had left, and the area health care manager now occupying the role of person in charge. This was the second change in the person in charge within a four month period. The assistant director of nursing post remained vacant since December 2018 and their had been a recent change in

Inspectors reviewed the assessed care needs of residents and tracked the journey of a sample of residents with dementia within the service. Inspectors met with
residents, relatives and staff and reviewed documentation such as nursing assessments, care plans, medical records and examined relevant policies including those submitted prior to inspection. Inspectors observed care practices and interactions between staff and residents who had dementia using a validated tool. Prior to the inspection, the provider completed the self-assessment questionnaire in relation to six outcomes. The self-assessment and inspection judgements are set out on the table above.

Staff turnover was high and five care assistant posts were not filled at the time of inspection. The roles and responsibilities of nurses were not clear and the induction programme for new nurses was inadequate. There was poor supervision of staff and this impacted on the standard of care being delivered. Residents with dementia who required support to undertake activities of daily living were not dressed in a dignified manner. Three of the communal rooms where they spent the day were cold and they did not have access to suitable social activities to meet their needs.

Inspectors also followed up on the action plan from the previous inspection in November 2017, and found all three had been progressed. While inspectors acknowledge that progress had been made in addressing areas of non-compliance, the findings of this inspection showed a significant deterioration in the centre’s level of compliance since the last inspection. Inspectors found that the care provided to residents with dementia required significant improvements to ensure the care provided was evidence based. Such was the level of concern, the provider representative accepted an invitation to a meeting with the Office of the Chief Inspector to discuss the findings outlined in this inspection report.

The findings are discussed in the body of the report and non compliances are outlined in the compliance plan at the end for response.
**Outcome 01: Health and Social Care Needs**

**Theme:**
Safe care and support

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

**Findings:**
Residents wellbeing and welfare was maintained, however the care being delivered to residents with dementia was not of a high standard and was not evidence based.

Inspectors focused on the experience of residents with dementia and tracked the journey prior to and since admission. The review also looked at specific aspects of care such as nutrition, wound care, mobility, access to health care and supports, medication management, end-of-life care and maintenance of records. Residents' healthcare needs were met through timely access to medical treatment. Residents had good access to a general practitioner (GP) and multidisciplinary professionals. Inspectors saw good evidence that advice received from the multidisciplinary team was followed up in a timely manner. The detail of reviews carried out was clearly evident within the records.

Residents' files held a copy of their Common Summary Assessments (CSARS), which detailed assessments undertaken by professionals such as a geriatrician and members of the multidisciplinary team. Residents were assessed on admission to the centre using validated tools and risk assessments completed, which were reviewed within a four month timeframe. Person centred care plans were in place. However the care plans for residents with dementia were not consistently implemented and the care provided was not person centred. Inspectors observed that a group of non-mobile residents who had dementia were cohorted into a small sitting room and left alone with little interaction with staff for long periods of time.

There was evidence of the resident and sometimes their next-of-kin being involved in the development of their care plan.

There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents. Residents' medications were prescribed by their general practitioner and these were reviewed on a frequent basis, usually within a three month timeframe. The administration of medication required review as it did not reflect the policy. The process used by nurses when administering medications was unsafe and increased the risk of an medication error occurring.
Arrangements were in place to meet the nutritional and hydration needs of residents with dementia. There were systems in place to ensure residents' nutritional needs were met and monitored on an ongoing basis. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked. The processes in place ensured that residents with dementia did not experience poor nutrition and hydration. Inspectors saw that a choice of meals was offered and available to residents. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Any food allergies were clearly recorded along with residents' likes and dislikes. Residents told inspectors they had their breakfast in bed and their lunch and tea in the dining room. Inspectors observed that staff sat with residents at meal times and provided encouragement or assistance with the lunch-time meal. Assistance was given to residents with dementia in a discreet and sensitive manner.

Staff provided end-of-life care to residents with the support of their GP and had access to specialist community palliative care services if required. End-of-life preferences were discussed with each resident and these were outlined in the residents person centred end-of-life care plan. Residents had access to religious representatives which ensured their religious needs were met at the time of death. Single bedrooms were available to residents occupying twin rooms at the time of death.

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:
Measures taken to safeguard residents with dementia from abuse were not robust.

There was a policy in place to safeguard residents and protect them from abuse. Inspectors observed that an alleged incident of elder abuse reported by a resident to a staff member in March 2019 and recorded in the complaints log had not been identified as an abuse issue and not investigated. The policy stated "the nursing home shall support the raising of concerns about the nursing home’s care staff and external third parties". The policy was not reflected in practice.

The policy stated that "Staff education regarding the safeguarding of residents from abuse shall be provided with the relevant education and training during staff induction, through formal education sessions and on an ongoing basis thereafter". However, this
was not implemented in practice. A number of staff spoken with who had completed their induction training, confirmed they had not completed safeguarding training. One nurse who spoke with inspectors did not have an good understanding of elder abuse. Inspectors were later informed that these staff were scheduled to attend elder abuse training.

There were systems in place to safeguard residents' finances. The centre was a pension agent for a number of residents, and inspectors found that the arrangements in place to manage this were in line with the Department of Social Protection guidelines. Records of residents monies held on their behalf were clear, concise and easy retrievable. Receipts of expenditures were included in the records reviewed. Residents had access to a record of their account on demand.

There was a policy and procedure in place to support residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Residents who displayed responsive behaviours had a comprehensive assessment completed. These residents had a person-centred care plan, those reviewed included known triggers and diversional therapies which worked effectively for the resident.

There was a low use of restraint in the centre. Residents had access to alternative equipment to restraint and this had lead to a progression towards a restraint free environment. For those with bedrails in use, a bedrail risk assessment and care plan was reflective of the care provided, however there was no documentary evidence that alternatives were trailed prior to bedrails being used.

**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:**
Systems to support consultation with residents were not utilised by management to maximise their participate in the organization of the centre. There privacy was respected however, they were not always dressed in a dignified manner. The opportunities to participate in meaningful activities appropriate to meet the needs of residents with dementia was limited.

Residents meetings were held on a monthly basis. These were chaired by an independent advocate, who also met with the residents. Minutes of residents' meetings
were available for review and indicated that issues raised were brought to the attention of the management but were not consistently addressed. For example the low temperature in some rooms and the non availability of hot water. Management did not use the scheduled resident monthly meeting to communicate with residents. For example, residents told inspectors they had not been informed of the refurbishment work being carried out or that the person in charge was leaving until the day of her departure. Relatives said they had been informed about the refurbishment via email.

Residents had access to daily and local weekly newspapers. Residents were seen reading these during the course of the inspection. Residents had access to televisions in their bedroom and in communal bedrooms and although the televisions in two of the communal rooms were not working on the first day of this inspection, they were operating effectively on day two. Residents had access to radio and long term residents living in the centre since 2018 had been registered to vote. Religious services were provided to residents in-house by external religious representatives coming into the centre. Mass was said in the centre on a monthly basis.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record these interactions at five minute intervals in two dining-rooms, one activity room and one lounge. Scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care), 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). The scores reflect the quality of the interactions with the majority of residents. Inspectors’ observations concluded that the majority of interactions consisted of neutral care, where staff did not inform the resident what they were going to do and did not engage with residents’ on an individualised basis. However, some reflected protective and controlling care. For example, a staff member was observed wheeling a resident, who was sleeping, from the sitting room to the dining room without speaking to the resident. Over the course of the inspection the inspectors observed several interactions where staff did not communicate in a person centred way with residents who had advanced dementia. Residents who required support with their activities of daily living were not adequately supported. Attention had not been paid to their personal appearance, for example, a number of residents with dementia found sitting in cold communal rooms did not have shoes or slippers on, their clothing was dishevelled and some residents did not have their hair brushed and their hands were cold to touch.

There was a schedule of activities posted in the centre. The activities on offer were not informed by the interests and capacity of the residents. Therefore, residents with dementia did not have access to meaningful activities. The recording system used did not detail the individual resident's level of engagement or participation in an activity. Activities were the responsibility of the activities co-ordinator. However, she spent most of her morning supervising a resident identified as at risk of falling. This meant that the activities co-ordinator although in the room with residents, was not available to chat with other residents or to support them to participate in social activities.

There was a newly refurbished enclosed garden, however residents were not supported to access it. Inspectors observed some residents with dementia who were restless and might have benefitted from fresh air or from outdoor exercise. Staff did not take them outside. Residents had not been facilitated to go on trips outside of the centre.
The layout of the building supported residents' privacy and meeting with visitors in communal areas or more private settings, in line with their preferences. There were no restrictions on visitors other than protected mealtimes.

**Judgment:**
Non Compliant - Major

### 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:**
There was a complaints policy in place that met the legislative requirements. It was not implemented in practice.

The complaints procedure was displayed in a place where it was visible to residents. Some relatives of residents with dementia told inspectors that they knew they could complain to the staff, but the complaints officer was not easily accessible. They felt that they were passed off by staff particularly at weekends. They were often told that the complaints officer would contact them about their reported issue on Monday and they were never contacted.

The person in charge was the nominated person to investigate and manage complaints. Verbal and written complaints were recorded in a complaints log that was maintained in the centre. Inspectors reviewed this log. One complaint on file had not been acknowledged or investigated in line with the policy.

**Judgment:**
Non Compliant - Moderate

### Outcome 05: Suitable Staffing

**Theme:**
Workforce

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.
Findings:
The staffing numbers and skill mix on duty was reflected on the staff roster. The number and skill mix on the day of inspection was adequate to meet the needs of the 41 residents, despite this the needs of residents with dementia were not being met.

There was a high turnover of staff. There were five vacant healthcare assistant posts, three had been filled but contracts had not yet been signed, two posts remained vacant. Most days there were two health care assistants on day duty and one on night duty employed from an agency. This had lead to inconsistencies in the standard of care being delivered to residents.

There was confusion among newly employed staff nurses about their roles and responsibilities. They told inspectors they had received one months induction where they worked along side health care assistants and had received a two day induction specific to their staff nurses role. The inspectors held the view that the induction programme was not adequate as it was their first time working as a registered staff nurse in Ireland.

Three staff who had been employed and working on the floor providing care to residents for over one month, had not received mandatory training in safeguarding residents against abuse or manual handling. Inspectors noted that although the choice to be resuscitated was available to residents, only 5 staff (16%) had received training in cardio-pulmonary resuscitation. Staff had attended dementia training in 2018 but the benefit of this training on practice was not evident to inspectors.

Recruitment procedures were in place. All documents as required by Schedule 2 of the regulations for staff were maintained.

Carers worked in teams of two, caring for a number of residents allocated to them. Inadequate arrangements were in place to supervise staff and ensure that residents received high quality care. This was evidenced in the poor standard of care found on inspection and the results of the observational study.

Volunteers came into the centre to support residents. They provided music therapy and religious services to residents. A sample of five files of persons identified as volunteers were reviewed. Each had their roles and responsibilities outlined and agreed with the person in charge. Two of the five reviewed did not have garda vetting in place.

Judgment:
Non Compliant - Major
**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:**
The premises did not meet the needs of residents with dementia. Heating in some bedrooms was inadequate and the temperature in three communal rooms was three degrees below the recommended temperature. Hot water was not consistently available in two corridors. Ongoing maintenance issues were not followed up.

The temperature in three of the four communal rooms was found to be consistently below the recommended 21 degrees centigrade. One of the rooms where eight maximum, immobile residents with dementia were residing in for the majority of this two day inspection was recording at 19 degrees centigrade. This room felt cool to inspectors and the residents hands were cool to touch, some residents acknowledged that they felt cold.

Inspectors were informed by relatives, residents and staff that hot water was not always available in two corridors where residents lived. Both these issues had been reported intermittently in the maintenance report book since January 2019 and the inadequate communal room temperatures was entered in the risk register. To date they had not been addressed. However, inspectors were informed that there was a problem with the boiler which had been repaired, the repairs had been ineffective. On day two of this inspection, inspectors were informed that a new boiler was being installed and this installation was completed at 15.30 hours. Written confirmation of the installation of a new boiler and a copy of the certificate of installation was not submitted to the Office of the Chief Inspector as requested at the feedback meeting conducted at the end of this inspection. Therefore, one of the inspectors visited the centre a week after this inspection to follow up on this issue and found that the communal rooms were warmer and she was informed that a new boiler had been installed.

Inspectors observed that the store room had now got ventilation installed and had been redecorated. The ventilation and lighting was not working in a number of communal bathrooms. These bathrooms had no windows and although they had a mechanical ventilation system in place this was not working in these bathrooms. There was a foul smell in each of these communal bathrooms. Inspectors were informed on day two of this inspection that a chemical was being put down the drains to attempt to minimise the foul smell. The risk associated with this problem although an ongoing issue was not entered in the risk register.

Some areas of the centre such as the visitors room and the sun lounge were decorated
in a bright and homely manner. One corridor which had six single ensuite bedrooms had been refurbished and redecorated, the size of these bedrooms had not changed. However the layout of furniture had. The bedrooms had new fitted wardrobes and storage facilities installed and the bed and call bell position had been changed. Inspectors noted that the bedrooms used by long term residents was not prioritised. Five of the six refurbished bedrooms were occupied by respite residents.

The corridors had been painted earlier in 2019 and appeared bright. However, there was nothing on the walls to make the premises appear homely.

The signage for naming each corridor was up too high for residents to see easily, it was above the door frame. There was an absence of pictorial signage or dementia friendly signage which would facilitate residents with dementia maintain their independence. There was little use of colour to enhance residents with dementia to orientate themselves around their home.

Catering and laundry facilities were available in the centre.

**Judgment:**
Non Compliant - Major

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**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:**
Key management positions were vacant and the governance and management of this centre was weak. The post of person in charge had been held by two people in the preceding six months. A new person in charge was due to take up post in May 2019 and the quality care manager had moved into the director of nursing post until May 2019. The assistant director of nursing post was also vacant and had been since November 2019, however inspectors were informed that someone had accepted and was taking up the post shortly.

The office of the Chief Inspector had not been informed of the change in the person in charge. However, an notification was submitted to the office of the Chief Inspector on day one of this inspection.

The oversight of the quality and safety of care being delivered to residents was not sufficiently robust. Although data on key performance indicators were gathered and reported to the quality care manager and audits of clinical practices were being completed, they were not reflecting or addressing the issues identified at residents
meetings or those reported by staff and relatives. Complaints and feedback from residents were not used to inform continuous quality improvement.

Poor governance had led to:
• significant deficits in the quality of service being delivered to residents,
• a lack of communication between management and residents,
• complaints not being responded to,
• an incident of alleged abuse not being investigated
• identified risks not being controlled or addressed.

An annual review for 2018 had been completed, it included residents feedback and an improvement plan. However, the improvement plan did not mention the current refurbishment of the centre and did not mention that planning permission had been sought for the development of the building.

 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:

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

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<tr>
<td>Date of inspection:</td>
<td>09/04/2019</td>
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<tr>
<td>Date of response:</td>
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Requirements

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

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

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The needs of residents with dementia were not being met in accordance to their individualised care plan.
The needs of residents with dementia were not being met in accordance with evidence based practice.

1. Action Required:

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
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:**
We will reassess the care needs of residents with dementia, using validated, evidence-based assessment tools, and based on these, the care plan of each resident will be updated, ensuring that this is an accurate reflection of individual residents’ assessed care needs. Care plans will be person-centred and will be updated in consultation with individual residents and their families, where appropriate. Care plans will reflect the residents’ expressed choices and preferences about how their health and wellbeing needs can be met and how we can optimise their lives in the centre.
We will develop Life Stories for each resident with dementia, as part of the social assessment, which will include A Key To Me, in order to help our staff to get to know the residents as individuals and to help them to understand how to improve the quality of person-centred care provided with compassion and sensitivity.
Arrangements will be made to improve the supervision of staff and to ensure that residents receive regular positive interaction, with plenty of opportunities to participate in meaningful activities.

**Proposed Timescale:** 31/07/2019

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The administration practices were not reflective of policy and did not mitigate the risk of error.

**2. 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:**
The medication administration procedures have been reviewed in the centre. All staff nurses will undertake a medication competency assessment. The nurses will carry out medication rounds using new medication trolleys which contain all the required prescribed medicinal products. Medications are safely administered from the trolleys by the nurses, in accordance with the medical prescription and the advice of the resident’s pharmacist. We will ensure that safe administration procedures are consistently maintained by providing supervision by the Clinical Nurse Manager and Assistant Director of Nursing. A monthly audit of medication management will be conducted and any areas of non-compliance will be recorded and addressed. A quarterly audit of medication management will be undertaken by the Pharmacist.
Proposed Timescale: 30/06/2019

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Where bedrails were in use, alternatives trialled prior to bedrails being used were not recorded.

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:
We will work towards minimal use of restraint in the centre. Where it has been deemed appropriate to use bedrails, we will ensure that this is a measure of last resort and a record of the decision to use the bedrail will be documented, which will show other measures considered. The use of any form of restraint in the centre will be in accordance with the centre’s policy and national guidelines. We will maintain a restraint register in the centre.

Proposed Timescale: 30/06/2019

Theme:
Safe care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
All reasonable measures were not taken to protect residents from abuse:
Two of five volunteers did not have garda vetting in place.
A reported alleged incident of abuse had not been investigated.
All staff did not have elder abuse training in place.

4. 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 and volunteers in the centre have garda vetting in place. The two volunteer musicians who did not have garda vetting on file on the day of inspection did not return to the centre until the garda clearance records had been obtained and filed in the...
centre.
The allegation of abuse has since been notified to the Authority and an investigation has been undertaken by the Person in Charge (PIC). The resident who made the allegation is reassured and satisfied by the actions take to ensure that such an incident does not occur again.

Education on safeguarding vulnerable persons at risk of abuse has been provided to all staff and refresher courses will be provided to those staff who have not recently received training on this essential aspect of care and protection.

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<td>Safe care and support</td>
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The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
All staff did not have training in relation to the detection and prevention of and responses to abuse.

5. 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 in the centre have received education on safeguarding vulnerable persons at risk of abuse. Newly appointed staff will receive education on safeguarding as part of their induction. Refresher training sessions on protection of residents and responding to abuse will be carried out to ensure that all staff remain vigilant and aware of how to recognise a potentially abusive situation if it occurs, their role in reporting any suspicion or allegation of abuse, and the role of staff and management in investigating and responding to any alleged abuse.

<table>
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<tbody>
<tr>
<td>Theme:</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The person in charge had not investigated a incident of alleged abuse reported by a resident.

6. Action Required:
Under Regulation 08(3) you are required to: Investigate any incident or allegation of abuse.
Please state the actions you have taken or are planning to take:
A complaint was logged which was not identified as a suspicion of abuse. The new PIC has notified the Authority and has undertaken an investigation into the incident. The resident at the centre of the incident is satisfied at the actions taken and reassured that the concerns raised have been addressed and resolved. The PIC will meet with residents and family members on a regular basis, ensuring that they continue to feel safe and happy in the centre. The PIC will ensure that she operates an ‘open-door’ policy, where staff, residents and relatives are aware that she is available to meet them to discuss any issues and concerns. The PIC, supported by the Assistant Director of Nursing (ADON) and Clinical Nurse Manager (CNM), will ensure that there is appropriate supervision of staff and will foster a culture of openness and transparency, where staff are encouraged to be open and transparent in safely reporting any issues and concerns they have about any aspect of care or service that may affect residents. The PIC will regularly monitor complaints and incidents, with a view to assessing whether there may be a suspicion of abuse or whether they could be construed as abusive situations. The PIC will notify all suspicions or allegations of abuse to the Authority and will conduct a preliminary screening to determine whether abuse might have occurred, in accordance with the centre’s policy on safeguarding and will proceed to a full investigation if abuse may have occurred. The PIC will adhere to the centre’s policy and national Safeguarding policy in relation to the legislative obligation to inform external agencies, such as the Safeguarding Office and An Garda Siochana, if appropriate.

Proposed Timescale: 31/07/2019

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:
Residents with dementia did not have access to a schedule of meaningful activities based on their interests.

7. 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:
As part of the overall reassessment of residents with dementia we will ensure that individual residents’ expressed choices and preferences are reflected in all aspects of care, including their social care needs. We will involve residents’ families in helping to understand each individual resident and getting to know them as a person. The development of Life Story books, as part of a dementia-specific social assessment, will include A Key to Me and this will guide staff about each residents’ likes, dislikes,
interests and preferred activities. The PIC will work with the Activities Coordinators in developing a range of varied and interesting activities for residents to participate in and will ensure that the schedule reflects the specific needs of residents with dementia. There will be opportunities for individual and group activity sessions. Reminiscence sessions, music, Sonas and Imagination Gym will be among the range of meaningful activities offered to residents with dementia. The Activities Coordinator will be facilitated to spend time chatting and engaging with residents in a purposeful way, focusing on their interests and wellbeing. There will be a record of residents’ participation and level of engagement in activities.

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**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
Residents with dementia were not always provided with a choice.

**8. Action Required:**
Under Regulation 09(3)(a) you are required to: Ensure that each resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.

**Please state the actions you have taken or are planning to take:**
We will ensure that there is a record of consultation with residents and their families regarding each individual residents’ choices, preferences and interests. This will be reflected in the overall care plan and in the Life Story of each resident with dementia and will guide staff in planning the daily lives of residents with dementia. All staff receive training in caring for residents with dementia as part of their induction. We will ensure that staff are encouraged to communicate with residents on a one to one basis, in a kind, patient and sensitive manner to allow each resident to express what they wish to do. Staff will offer residents choices wherever possible, such as choosing their own outfit for the day, when to get up, whether they would like to go outside and when they wish to go to bed, for example. We will provide a choice of menu at every mealtime and ensure that the resident chooses the meal of their preference. Pictorial menus will be provided for residents with dementia to assist them in making a choice. There is a newly refurbished secure garden and residents will be offered opportunities to go outside for fresh air and exercise if they wish. We will consult residents and their families about planning daytrips outside the centre and these will be facilitated.
Proposed Timescale: 31/08/2019

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The management team were not informing residents of what was happening in their home.

9. Action Required:
Under Regulation 09(3)(d) you are required to: Ensure that each resident is consulted about and participates in the organisation of the designated centre concerned.

Please state the actions you have taken or are planning to take:
The management team will schedule regular resident and family meetings in the centre. There will be an opportunity for residents and families to engage in discussion on a wide range of operational services in the centre that may affect residents’ quality of life and wellbeing, including, quality of care, staff, catering, housekeeping, laundry, maintenance and any planned developments in the centre. Residents will be consulted about proposed upgrades or works planned for the centre and they will be informed about any repairs or works required to resolve problems that may occur from time to time. Minutes of the meetings will be available in the centre.

Proposed Timescale: 31/08/2019

Outcome 04: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The complaints policy was not implemented in practice.

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

Please state the actions you have taken or are planning to take:
We actively encourage feedback, comments and suggestions from residents and families, including negative comments they may wish to make. The PIC will ensure that she is available and accessible to residents and relatives to discuss issues or concerns they may have regarding care or services within the centre. The PIC will address any complaints and respond to the complainant verbally and/or in writing in accordance with the centre’s Complaints Procedure. We will review all complaints and implement quality improvements wherever possible in order to prevent recurrence of any adverse experience for residents and their families.
We will ensure that all nursing staff understand the complaints policy and procedure, so that they can act responsibly at weekends or in the absence of the PIC in addressing concerns or complaints. The PIC will follow consistently up on all complaints received, including those received in her absence.

**Proposed Timescale:** 31/07/2019  
**Theme:**  
Person-centred care and support  

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**  
Complaints made were not investigated promptly.

11. **Action Required:**  
Under Regulation 34(1)(d) you are required to: Investigate all complaints promptly.

Please state the actions you have taken or are planning to take:  
The PIC will be supported by senior management to investigate all complaints thoroughly and to ensure that a comprehensive response is provided to ensure that the complainant is satisfied that all aspects of the complaint were addressed.

**Proposed Timescale:** 31/07/2019  
**Theme:**  
Person-centred care and support  

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**  
The person nominated to oversee complaints was not effective in the role.

12. **Action Required:**  
Under Regulation 34(3) you are required to: Nominate a person, other than the person nominated in Regulation 34 (1)(c), to be available in a designated centre to ensure that all complaints are appropriately responded to and that the person nominated under Regulation 34 (1)(c) maintains the records specified under in Regulation 34 (1)(f).

Please state the actions you have taken or are planning to take:  
The Healthcare Manager will be responsible for ensuring that complaints are investigated and addressed and that appropriate records of all correspondence are maintained in the centre.

**Proposed Timescale:** 31/07/2019
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff did not have access to mandatory manual handling or safe guarding training prior to commencing employment in the centre.
Staff did not have access to cardio-pulmonary resuscitation training in a timely manner.

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

**Please state the actions you have taken or are planning to take:**
We will provide mandatory training to staff as part of their induction programme, including manual handling, safeguarding and cardio-pulmonary resuscitation as appropriate.

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not adequately supervised to ensure evidenced based nursing care was delivered at all times.

### 14. 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:**
We are in the process of enhancing the clinical management team in the centre. A Clinical Nurse Manager provides support and supervision to ensure that evidence-based care is delivered. She will report to the Assistant Director of Nursing (ADON) who is responsible for clinical leadership, staff deployment and provision of appropriate supervision in the centre. The PIC will be supported in the overall operation and management of the centre by a Healthcare Manager, who will monitor compliance with standards.
**Proposed Timescale: 31/08/2019**

**Theme:**
Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Two persons identified as volunteers did not have a garda vetting disclosure in place.

**15. Action Required:**
Under Regulation 30(c) you are required to: Provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 for people involved on a voluntary basis with the designated centre.

Please state the actions you have taken or are planning to take:
Two volunteers who did not have a garda vetting disclosure in place on the day of inspection will not return to the centre until evidence of garda clearance is available for inspection in their files. An application for garda clearance has been commenced for both volunteers.

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**Proposed Timescale: 30/06/2019**

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The heating in four communal rooms was not suitable for residents using these rooms.

**16. 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:
The Oil Boiler was replaced with a Gas Boiler on the 10th April (Commissioning Cert attached) This has improved the overall heating control in the Home. All room sensors are now set at 21°C and the thermostats can only be readjusted centrally at the Nurses Station. We will monitor the individual room temperatures carefully as rooms which are south facing may be at risk of overheating during extended sunny periods heading into the summer.

An issue was identified in the manifolds on the underfloor heating which were not opening and closing effectively. Work is in progress to upgrade all the manifolds which should improve the reaction time of the heating.
**Proposed Timescale:** 31/05/2019

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
A sufficient supply of hot water was not available to residents at all times.

**17. 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:
The replacement of the oil boiler with a gas boiler on the 10/04/2019 has improved the production of hot water to all outlets. Random inspections have been undertaken by the Facilities Team to ensure that the temperature readings remain consistent. The Maintenance Person will undertake regular monitoring when he is in the centre, 3 times per week, of all outlets for a 2 week period and then weekly checks thereafter to ensure this issue is resolved.

**Proposed Timescale:** 30/06/2019

**Theme:**
Effective care and support

**The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:**
The mechanical ventilation available in a number of communal bathrooms was not working.
The lighting in a number of communal bathrooms was not working.
A number of communal bathrooms were not independently accessible to residents.
The dining room was not independently accessible to residents.
One assisted shower was not working, the hose fitting was no in place.
The signage was not meeting the needs of residents with dementia.
The internal decoration was not focused on meeting the needs of those with dementia.

**18. 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:
On the day of the inspection, a Contractor had just commenced works on one wing of the centre. As a result they had disconnected the power on this wing. There is an assisted shower room, an assisted bathroom, a sluice room, a store room and a WC which were disconnected also as a result. With no power the extraction was not operational. This was discovered late on the evening of the 09/04/2019 and the electrician returned on the following morning to restore power and ventilation to these rooms. All fans were working by the second day of inspection however, we will replace the fans in the rooms without windows to help improve ventilation in these areas.

In relation to lighting in communal bathrooms, these are the same rooms referred to in above and power was restored on the morning of 10/04/2019.

In relation to independent access to communal bathrooms by residents: the mechanical keypad controls on these doors have been removed by the Maintenance Person.

On the dining room door, there was an electromagnetic lock with keypad control on these doors which was removed following the inspection. We will put measures in place to secure the kitchen, staff canteen and staff changing room which are all accessible from the dining room area.

The missing shower hose has been replaced by the Maintenance Person on 09/04/2019.

New dementia-friendly signs are being made up to identify each bedroom wing and will be positioned at a lower level for residents to identify with. Dementia-friendly signs with pictorials have also been ordered for the main communal rooms (Dayroom, Dining Room etc.). Signage is due for delivery by 10/10/2019.

We will develop a programme of works to upgrade areas of internal decoration to better meet the needs of residents with dementia.

Proposed Timescale: 10/10/2019