<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Lisdarn Centre for the Older Person</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000490</td>
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<tr>
<td>Centre address:</td>
<td>Lisdarn Centre, Cavan.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>049 437 3190</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:jenny.smyth@hse.ie">jenny.smyth@hse.ie</a></td>
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<tr>
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</tr>
<tr>
<td>Registered provider:</td>
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<tr>
<td>Provider Nominee:</td>
<td>Rose Mooney</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>PJ Wynne</td>
</tr>
<tr>
<td>Support inspector(s):</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 1 day(s).

The inspection took place over the following dates and times
From: 26 September 2017 09:20
To: 26 September 2017 18:55

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>
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<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td></td>
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<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
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<td>Non Compliant - Moderate</td>
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<td>Outcome 04: Complaints procedures</td>
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<td>Outcome 05: Suitable Staffing</td>
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<td>Outcome 06: Safe and Suitable Premises</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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Summary of findings from this inspection
This report sets out the findings of an unannounced thematic inspection. The purpose of this inspection was to determine what life was like for residents with dementia living in the centre.

Prior to this inspection the provider had submitted a completed self-assessment document to the Health Information and Quality Authority (HIQA) along with relevant polices. The inspector reviewed these documents prior to the inspection.

The inspector met with residents, staff members and the person in charge. The inspector tracked the journey of residents with dementia and observed care practices and interactions between staff and residents. A formal recording tool was used for
this purpose. Documentation to include care plans, medical records and staff files were examined.

The centre can accommodate a maximum of 32 residents in two separate units. Unit one accommodates a maximum of 18 residents for long term care. Unit two accommodates a maximum of 14 residents on a short term basis for periods of convalescent or rehabilitative care. This inspection was undertaken in unit one where residents were residing on a continuing care basis.

The centre does not have a dementia specific unit. The majority of residents were in advanced old age with eight residents over 85 years of age. Seven residents had a diagnosis of dementia or some degree of cognitive impairment of which three were formally diagnosed. There was one resident under 65 years residing in the centre on the day of inspection.

The centre met the individual care needs of residents with dementia. Residents were well known by staff and the care needs of residents with dementia were met. There was a relaxed atmosphere in the centre and residents told the inspector they were happy with the care, attention and living in the centre.

Residents rights were respected and this was seen through the range of choices available to people about how and where to spend their time. The observations carried out in the sitting and dining room areas found staff were engaging positively with residents using a range of communication methods and sensory engagement.

Residents’ healthcare needs were well met. A medical officer visits the centre each week day and on call services were available out of hours and at the weekends. A range of allied health services were available on referral including speech and language therapy, dietetic services and occupational therapy services.

There was an appropriate number and skill mix of staff to meet the assessed health and social care needs of residents. Staff optimised opportunities to engage with residents. There was a social and recreation program organised daily facilitated by a diversional activity therapist.

The premises did not meet the needs of all residents in that the layout, specifically the bedroom accommodating four residents. It did not meet their individual and collective needs and fully ensure privacy. There was inadequate storage space for clothing and the storage of personal possessions and limited personal space around individual beds in this bedroom.

A total of seven outcomes were inspected. The Action Plan at the end of this report identifies the areas where improvements are required to comply with 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.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

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

Findings:
This outcome sets out the inspection findings relating to healthcare, assessments and care planning. There were seventeen residents in Unit one in the centre when the inspection was undertaken. The inspection focused on unit one which accommodates residents for long term care. There were 10 residents with maximum dependency care needs and six were assessed as highly dependent. One resident had medium dependency care needs.

The majority of residents were in advanced old age with eight residents over 85 years of age. Seven residents had a diagnosis of dementia or some degree of cognitive impairment of which three were formally diagnosed. There was one resident under 65 years residing in the centre on the day of inspection.

Pre admission assessments were generally conducted by the person in charge which considered the health and social care needs of potential resident. The majority of residents admitted to unit one were discharged from the acute hospital on site to unit two of the centre. Unit two accommodates residents for short periods of time and provides transitional or convalescent care. On the day of inspection one resident was moving into long term care from unit two in the centre.

Many residents were noted to have a range of healthcare issues and the majority had more than one medical condition. The nursing team were managing some complex medical care issues. Four residents had a percutaneous endoscopic gastrostomy (PEG), (a feeding tube which is placed through the abdominal wall and into the stomach allowing nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth). The care pathway for each resident who required this intervention was described well in care plans. One resident required tracheostomy care (a tube which is inserted into the windpipe to assist breathing). Staff had received training in tracheostomy care and had good support from the multi-disciplinary team in the acute hospital located adjacently.

Residents’ healthcare needs were well met. A medical officer visits the centre each week
day and on call services were available out of hours and at the weekends. When
needed, residents were transferred to hospital for investigation and treatment. Residents
were facilitated to attend appointments for investigations and reviews.

The inspector tracked a sample of residents’ care plans and found that timely and
comprehensive assessments were carried out and appropriate care plans were
developed. On admission a comprehensive assessment was completed. A range of
clinical risk assessments were completed and were used to evaluate residents’ progress
and to assess levels of risk for deterioration, for example vulnerability to falls, nutritional
care, the risk of developing pressure sores, continence needs and cognitive functioning.

These were used to develop care plans that were individualised and described the
current care to be given. There was good linkage between assessments completed and
developed plans of care. Care plans for personal care, nutrition and mobility described
well each resident’s independence and the level of assistance and support required.
Clinical assessments were generally repeated on a four-monthly basis or sooner if there
was a change in a residents condition and care plans evaluated accordingly.

Relatives the inspector talked to confirmed that staff consulted with them regularly.
However, there was limited evidence available that the care plans were made available
to the resident or discussed with their next of kin on the resident's agreement. In some
care plans reviewed there was no documentation evidencing communication of
consulting with the resident or their next of kin on their care plans for over 12 months.

Details were available on residents’ backgrounds and lifestyles and this was used to
inform care practice. Each resident has a life story book. This was available for staff to
review and aid communicating with residents with dementia. The books contained
photos of past life events, pictures of their families and locality. While residents had
personal profiles developed with details of their life history this information was not
reflected or linked into care plans to manage problems related to their dementia. Further
detail is required within care plans for residents with dementia or impaired cognition to
detail the level of confusion or cognitive impairment and how it impacts on daily life for
the resident. Information such as who the resident still recognises or what activities can
still be undertaken.

A range of allied health services were available on referral including speech and
language therapy, dietetic services and occupational therapy services. Physiotherapy,
chiropody and optical services were also available. The inspector reviewed residents’
records and found that where residents had been referred to allied health professionals
the outcome of appointments and recommendation were recorded in residents’ notes
and transferred to care plans.

All residents were appropriately assessed for nutritional needs on admission and were
reviewed regularly. The care plans of those residents with dementia which were
reviewed contained relevant assessments including risk in relation to safe swallowing
and adequate nutritional intake. Good communication existed to ensure that all staff to
include care, nursing and catering had up to date knowledge of each residents dietary
requirements. Throughout the inspection residents were seen to be provided with
regular snacks and drinks. Residents who required support at mealtimes were provided
with timely assistance from staff.

There were no residents with pressure ulcers on the day of inspection. Residents identified at risk of developing pressure ulcers had specific equipment in place to mitigate the risk, such as repositioning regimes, pressure relieving mattresses and cushions to protect skin integrity. The majority of residents were provided with air mattress and additional mattresses were available in the centre. Advise from a clinical nurse specialist in wound management is available as required.

Each resident had a plan of care for end-of-life needs. End-of-life care plans recorded detail of personal and spiritual wishes to assist meeting social and psychological needs. There was an end-of-life care policy detailing procedures to guide staff. The policy of the centre is all residents are for resuscitation unless documented otherwise. The nursing team confirmed they had good access to the palliative care team who provided advise to monitor physical symptoms and ensure appropriate comfort measures. There was one resident under the care of the palliative team at the time of this inspection.

**Judgment:**
Substantially Compliant

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**Outcome 02: Safeguarding and Safety**

**Theme:**
Safe care and support

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

**Findings:**
Measures to protect residents being harmed or suffering abuse in the centre were in place. Residents said that they felt safe and attributed this to staff being available to talk to and having confidence in them to help. One resident described how kind staff were to her when she becomes anxious and ‘they take the time to help and always get me a cup of tea’.

There was a policy and procedures in place to guide staff in the safeguarding of vulnerable adults. All staff had completed training on the Health Service Executive (HSE) national policy on safeguarding vulnerable adults. This was an area identified for improvement in the action plan of the previous inspection. There was one notifiable incident reported since the last inspection in relation to safeguarding. This was reported to the safeguarding team and a safeguarding plan developed. This was reviewed on inspection. There was evidence residents are appropriately safeguarded at all times by the provider and the person in charge.

Staff, with whom the inspector spoke stated that they were knowledgeable of the types of abuse that could occur and they were aware of their reporting responsibilities. Staff
spoke confidently that they would recognise an abuse situation and would relay any situation that they had concerns about to the person in charge.

Through observation and review of care plans it was evidenced staff were knowledgeable of residents’ needs and provided support that promoted a positive approach to the behaviours and psychological symptoms of dementia (BPSD). Staff were seen to reassure residents and divert attention appropriately to reduce anxieties in observations undertaken by the inspector. Staff spoken with were familiar with residents’ daily routines.

Residents with dementia who displayed fluctuating and changeable behaviours had a care plan in place to guide staff when supporting residents. Incidents of responsive behaviours were recorded and the inspector saw that staff helped residents appropriately and sensitively during periods when they were restless or anxious. Where residents were unable to communicate an unmet need or a change in behaviour there was evidence of exploring issues. Nursing staff spoke to the inspector of firstly monitoring for infections, constipation, and changes in vital signs in order to establish the cause of behaviours. The management of pain was well documented.

A member of staff is involved in a training program being led by the psychiatry team and the Health Service Executive (HSE) titled, Functional Interventional Training System (FITS). The staff member had a lead role in developing an onsite program to ensure the well being of residents living with dementia through a holistic model. The staff member had a lead role in auditing the use of antipsychotic, anti anxiety medicines and night sedatives in conjunction with the team. Changes to medicines were trialled and the number prescribed antipsychotic medicines overall was reduced during the program. There was good access to the psychiatry of later life team. The community mental health nurse from the team visited the centre regularly to review one resident. Other residents were discharged back to the care of their GP.

There was a policy on restraint management (the use of bedrails and lap belts) in place. There were risk assessments completed for residents who had bed rails in place. A movement assessment was completed for three day period to inform the need for bedrails and a risk balance tool was completed on the initial assessment. There was evidence of trialling alternative options prior to using bedrails and the reason why they were unsuccessful. While restraint risk assessments were reviewed periodically there was no further exploring of options to determine if some residents only required one bedrail raised or continued evidence of exploring alternative less restrictive measures through audits and individual care plan reviews. The movement risk assessment was not repeated to inform the judgement to continue using bedrails.

**Judgment:**
Substantially Compliant

**Outcome 03: Residents’ Rights, Dignity and Consultation**

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

**Findings:**
All staff optimised opportunities to engage with residents and provide positive connective interactions. There appeared to be a positive and friendly atmosphere in the centre.

While there were visiting times displayed to ensure meal times were protected, in practice there was no restriction on when residents could receive visitors. Many residents were observed spending time with family or friends in the varied sitting areas throughout the day. There is a visitor’s room where residents can meet with visitors in private and this was used during the inspection.

There was a good range of specialist equipment and appliances such as hoists, wheelchairs and walking aids available to support and promote the independence of residents. One resident had a motored bike placed closed to his bed on which he completed his daily cycling exercises.

The inspector spent time observing staff and resident interactions during the morning and afternoon using the observation tool QUIS. These observations took place in two communal sitting areas and were completed over selected time frames. The engagements observed were all of a positive nature. The inspector saw that staff engaged residents in conversation whenever they were nearby. When passing through any area where residents were sitting they greeted residents and took time to speak with them. Staff were familiar with residents' day to day physical care needs, family backgrounds and interests and used these aspects of life to chat with them about their family and the news of the day.

During lunch time the inspector observed that staff were available in sufficient numbers to serve meals and to assist residents in a discreet and sensitive manner. The inspector observed that staff reminded residents of the menu choices and reminded them of the options as the meal progressed. The inspector observed that residents were given plenty of time to have meals in comfort and staff communicated and engaged with residents while assisting them.

There was a varied social and recreation programme organised daily. This was on display in the sitting room. There are two diversional activity therapist employed one assigned to each unit. The inspector spoke with both staff members. One staff member had completed training in Imagination Gym recently which encourages people to visualise a particular scene. There were specialist activities targeted to meet the needs of people with dementia and these included Sonas- which is a sensory and music programme. The activity therapist assigned to unit one was trained in Sonas and spoke to the inspector at length regarding the individual activities she undertook with residents. She outlined the individual activities she assisted with for residents who did not like to partake in group activities. She conveyed a good understanding of the needs
of all residents and had tailored activities for individual residents. Residents spoken with described the various activities she helped them with including individual passive exercises, reading the local newspapers and bingo which was a favourite with many residents. Records were maintained on a daily basis of each resident’s participation in social activity and their level of engagement. Where residents chose not to take part this was recorded.

The weekly programme included visits from a therapy dog, bingo sessions, passive exercises. Newspapers including local papers were available as observed by inspectors. Residents were facilitated to practise their religious beliefs. Mass was available in the centre regularly. Ministers of other religious denominations visited routinely.

There were regular resident’s meetings, and minutes were available. The minutes showed that they were read out and agreed at the following meeting. Residents were encouraged to participate and the meeting was supported by the diversional activity therapist. The meeting evidence residents’ feedback both collectively and individually was sought. Feedback was taken on board, for example changes to the menu were facilitated following specific requests.

The person in charge had completed a survey to elicit the views of residents or their next of kin to provide the opportunity to participate in the organisation of the centre. A resident/relative satisfaction surveys or questionnaire were completed by residents or their next of kin to elicit their views or comments on the service provided. There was a high response rate and comments for areas of improvement were addressed.

Residents had access to an independent advocate. The advocate had visited the centre to support two residents over the past year. One resident was provided with a counselling service to support in relation to personal anxieties being experienced.

The inspector found that the multiple occupancy bedrooms did not promote residents’ privacy and dignity fully. While screens were provided around beds when personal care was being delivered they restricted access to the bedrooms for short intervals at busy periods in the morning when residents were being assisted to get up. As described in Outcome 6 Safe and Suitable Premises, the bedroom accommodating four residents was not suitable in size to meet the collective and individual needs of residents and ensure their privacy and dignity. There was inadequate storage space for clothing and the storage of personal possessions and limited personal space around individual beds.

Judgment:
Non Compliant - Moderate

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:
Policies and procedures were in place for the management of complaints. The complaints procedure was in a flow diagram format. It was not available in an easy to understand format to inform anyone with an issue how to make a complaint. The local complaints procedure was not on display as required by the regulations.

The person in charge maintained a record of all the complaints in the centre. The inspector reviewed the complaints record and found they were recorded on a standard complaints template. The template listed the dates, times, details of the complaint and details of any actions taken on the receipt of a complaint. Two written complaints were investigated during the year. Meetings were held with the complainants and the matters fully responded to by the person in charge.

Residents spoken with said they were aware of how to make a complaint and identified the person in charge as the person they would approach if they had an issue of serious concern but that most of the time they would tell any member of staff. Residents had access to an advocate if required to assist them in making a complaint.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
Residents spoke very positively of staff and indicated that staff were caring, responsive to their needs and treated them with respect and dignity. This was seen by the inspector throughout the inspection. In particular, residents with dementia were seen to be supported by staff in a dignified, person centered and caring manner.

Systems of communication were in place to support staff with providing safe and appropriate care. There were handover meetings each day to ensure good communication and continuity of care from one shift to the next. The inspector saw records of regular staff meetings at which operational and staffing issues were discussed.

There was a clear management structure in place and staff were aware of the reporting mechanisms. There was an appropriate number and skill mix of staff to meet the
assessed health and social care needs of residents. There were two nurses rostered from 08.00hrs until 4.30hrs each day who report to a clinical nurse manager in the unit. There are four care assistant rostered throughout the morning and three until 8.00pm. There is a diversional activity therapist, catering and cleaning staff available on the unit.

Staff demonstrated a clear understanding of their role and responsibilities when spoken with. They were found to be knowledgeable of residents' needs and the responsibilities of their respective roles.

An induction system was in place for new staff. The inspector spoke to a newly recruited staff member who was working in a super numeracy capacity on the day of inspection. The employee confirmed she was required to submit references, Garda vetting forms and evidence of qualification and training prior to commencing in post. She was working alongside a staff member of the same grade to become familiar with residents and their care requirements.

Staff training records demonstrated a proactive commitment to the on-going maintenance and development of staff knowledge and competencies in line with residents' needs. All staff employed had completed mandatory training in relation to fire training, safe moving and handling instruction and safeguarding of vulnerable adults. Staff had completed training in professional management of violence and aggression (PMAV) and the majority of staff were trained in cardio pulmonary resuscitation techniques. Training on dementia care and associated behaviour had been completed by several members of the staff team. However, not all nursing and care staff had completed training in caring for residents with dementia to account the varied range of dementia care needs encountered by staff.

The inspector reviewed the personnel records for five staff and found that they were compliant with the requirements of Schedule 2 of the regulations. The person in charge gave verbal assurance all staff had required vetting including volunteers attending the centre.

**Judgment:**
Substantially Compliant

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**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

**Findings:**
The majority of the bedrooms in the centre were multiple occupancy rooms for between two and four residents. The maximum number of residents accommodated in each
multiple occupancy bedroom has decreased over the past number of years to presently a maximum of three residents in each bedroom area except for one bedroom where four residents are accommodated.

There was a sufficient number of toilets, showering facilities to meet the number and needs of residents accommodated. Residents’ could have the option to have a bath if they wished.

All of the bathrooms have been upgraded with new sanitary fittings. The walls and floors of bathrooms have been provided with new easily cleanable finishes. There were grab rails and call bells provided to support residents’ independence. The building was well lit, heated and ventilated.

There is a bedroom designated for end of life care. The bedroom is suitable in size, well furnished and ensured privacy for residents. A sofa is provided to facilitate families stay overnight and families have access to a visitor’s room and facilitates to make refreshments.

The reduction in the number of residents accommodated has increased the amount of personal space available for residents in multiple occupancy bedrooms. While there was sufficient space in the bedrooms accommodating three residents. One resident kept his motormed close to his bed space and there was sufficient room for him to complete his exercise comfortably. Another resident in this bedroom chose to have his meals in the bedroom. There was a separate table set by the window where he like to spend his time reading and looking out. There was good level of natural light in all bedrooms due to the wide windows.

However, the bedroom accommodating four residents was not suitable in size to meet the collective and individual needs of residents and ensure their privacy and dignity. There was inadequate storage space for clothing and the storage of personal possessions. There was limited personal space around the bed to facilitate specialist equipment without imposing on residents in adjacent bed spaces in the four bedded room.

Work to modernise the unit and improvements to the environment to create a homely atmosphere were evident. In the entrance foyer to the separate units two wall murals, floor to ceiling in height to reflect landscape scenes have been positioned. The murals give good visual impact on entering the units and provide a focal point of interest and diversion. The floor covering on the main corridor was replaced since the last inspection. The walls of the hallway were painted and modern lights were fitted along the walls. Handrails were a different colour from the wall and easy to distinguish.

The dining and sitting room was decorated and furnished in a way that prompted memory and orientation that defined its main purpose. The décor assisted to orientate residents. The dining tables were covered with red check tablecloths and matched with voile drapes around windows. A new jigsaw dining table has been obtained. This has a design that allows residents in specialised chairs to access the table easily and there is space for care staff to sit alongside residents to assist those requiring help with their meals. The furniture in the sitting room was comfortable and homelike. A fireplace was
a focal point of the room. There was a dresser with ornaments. Residents seating was arranged in a circular arrangement with chairs positioned towards the fireplace.

There was good use of visual cues and signage throughout the unit to help guide and orientate residents. Coloured pictorial signs were place on the doors of the sitting, dining room and bathroom to help orientate residents. All bedrooms and communal rooms were provided with dementia friendly clocks which had cues to indicate morning, afternoon and night time.

**Judgment:**
Non Compliant - Moderate

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### Outcome 07: Health and Safety and Risk Management

**Theme:**
Safe care and support

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

**Findings:**
Residents were regularly assessed for risk of falls. Care plans were in place and following a fall, the risk assessments were revised. A post fall review for completed to identify any possible contributory factors for example changes to medicines or infection. An audit of falls was completed by the person in charge to identify any possible trends in relation to the time, location or repeat falls by a resident.

The training records showed that staff had up to date refresher training in moving and handling. There was sufficient moving and handling equipment available to staff to meet residents’ needs. Moving and handling risk assessments were completed for each resident. These were available for reference by care staff in residents’ bedroom located on the inside of wardrobe doors. They outlined the type of hoist and sling size required.

Access and egress to and from the building was secured in the interest of safety to residents and visitors. There is a receptionist based at the main entrance during the day and in the evening the main entrance is secured and visitors are admitted by staff. Since the last inspection there were two reported incidents of a resident leaving the centre unaccompanied. There was one fire exit door which was not alarmed. This has since been alarmed and on checking during inspection the alarm activated when the door was opened.

There were procedures to undertake and record internal fire safety checks. Monthly and weekly fire safety checks were undertaken. The fire extinguishers were checked to ensure they were in place and intact, the fire panel and automatic door closers were operational. Records were maintained evidencing the fire escape routes were
unobstructed. There was an on-going programme of refresher training in fire safety evacuation. This was facilitated by an external trainer.

While fire drill practices were completed as part of annual fire safety training, regular fire drills were not completed routinely to reinforce knowledge from annual training. Drills with records maintained were not completed to reflect different possible fire scenarios on a routine basis in house by the person in charge, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to a simulated scenario in particular night time situation when staff levels are reduced. This was an area identified for improvement in the action plan of the previous inspection report which has not been satisfactorily completed.

Judgment:
Non Compliant - Moderate

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:

PJ Wynne
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

<table>
<thead>
<tr>
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<th>Lisdarn Centre for the Older Person</th>
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<tbody>
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<td>OSV-0000490</td>
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<tr>
<td>Date of inspection:</td>
<td>26/09/2017</td>
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Requirements

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

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

Outcome 01: 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:
There was limited evidence available that the care plans were made available to the resident or discussed with their next of kin on the resident’s agreement. In some care plans reviewed there was no documentation evidencing communication of consulting with the resident or their next of kin on their care plans for over 12 months.

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(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:**
All residents will have a care plan which will clearly demonstrate evidence of discussion and or agreement with each residents or their families.

**Proposed Timescale:** 01/12/2017

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Further detail is required within care plans for residents with dementia or impaired cognition to detail the level of confusion or cognitive impairment and how it impacts on daily life for the resident. Information such as who the resident still recognises or what activities can still be undertaken was absent.

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

**Please state the actions you have taken or are planning to take:**
All residents with dementia or impaired cognition will have care plans that will provide detail on the level of confusion or cognitive impairment and how this impacts on their daily life. This care plan will include detail of who the resident still recognises and what activities that they can still undertake.

**Proposed Timescale:** 01/12/2017

**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:**
While restraint risk assessments were reviewed periodically there was no further exploring of options to determine if some residents only required one bedrail raised or continued evidence of exploring alternative less restrictive measures through audits and individual care plan reviews. The movement risk assessment was not repeated to inform the judgement to continue using bedrains.

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

**Please state the actions you have taken or are planning to take:**
All residents with 2 bedrails will have alternative options explored through audits and care plan review. The movement risk assessment will be carried out on the identified residents so as to inform the judgement on continuing bedrails. This process will be ongoing with a focus on reducing the use of bed rails in the unit.

**Proposed Timescale:** 08/01/2018

**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:
While screens were provided around beds when personal care was being delivered they restricted access to the bedrooms for short intervals at busy periods in the morning when residents were being assisted to get up.

4. **Action Required:**
Under Regulation 09(3)(b) you are required to: Ensure that each resident may undertake personal activities in private.

**Please state the actions you have taken or are planning to take:**
Each resident will be consulted with and will be given the opportunity to undertake personal activities in private.

**Proposed Timescale:** 20/10/2017

**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 local complaints procedure was not on display as required by the regulations.

5. **Action Required:**
Under Regulation 34(1)(b) you are required to: Display a copy of the complaints procedure in a prominent position in the designated centre.

**Please state the actions you have taken or are planning to take:**
The complaints procedure is now displayed in the reception area.

**Proposed Timescale:** 20/10/2017  
**Theme:** Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The complaints procedure was in a flow diagram format and was not in an easy to understand format to inform anyone with an issue how to make a complaint.

6. **Action Required:**  
Under Regulation 34(1)(e) you are required to: Assist a complainant to understand the complaints procedure.

**Please state the actions you have taken or are planning to take:**  
The complaints procedure is now displayed in an easy to understand format in reception to inform anyone with an issue how to make a complaint.

**Proposed Timescale:** 20/10/2017

<table>
<thead>
<tr>
<th>Outcome 05: Suitable Staffing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme:</strong></td>
<td>Workforce</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Not all nursing and care staff had completed training in caring for residents with dementia to account the varied range of dementia care needs encountered by staff.</td>
</tr>
<tr>
<td><strong>7. Action Required:</strong></td>
<td>Under Regulation 16(1)(a) you are required to: Ensure that staff have access to appropriate training.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>A training DVD has been purchased to roll out on site training for all staff. This will be mandatory for all staff and the Practice Development Nurse will link with the Person In Charge to carry out audit of this training. Practice Development Nurse will link with the CNME regarding additional training that maybe required.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong></td>
<td>28/02/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 06: Safe and Suitable Premises</th>
<th></th>
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</thead>
</table>
**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The bedroom accommodating four residents was not suitable in size to meet the collective and individual needs of residents and ensure their privacy and dignity. There was inadequate storage space for clothing and the storage of personal possessions. There was limited personal space around the bed to facilitate specialist equipment without imposing on residents in adjacent bed spaces in the four bedded room.

**8. Action Required:**
Under Regulation 17(1) you are required to: Ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.

**Please state the actions you have taken or are planning to take:**
The next female bed vacancy in unit 1 will not be replaced by an extended care resident. This will mean that the 4 bedded cubicle will reduce to accommodating 3 beds. This will be reflected in the Statement of Purpose as and when it occurs. We will ensure that the premises are appropriate to the number and needs of the residents.

**Proposed Timescale:** 31/12/2017

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**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:**
Regular fire drills were not completed routinely to reinforce knowledge from annual training. Drills with records maintained were not completed to reflect different possible fire scenarios, including the time taken to respond to the alarm, for staff to discover the location of a fire and safely respond to a simulated scenario in particular a night time situation when staff levels are reduced.

**9. Action Required:**
Under Regulation 28(1)(e) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and residents are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
Fire Drills onsite will take place to reflect different scenarios, including the time to respond to the alarm, for staff to discover the location of a fire and safely respond to a simulated scenario in particular a night time situation when staff levels are reduced.
**Proposed Timescale:** 31/10/2017