<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mill Lane Manor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000066</td>
</tr>
<tr>
<td>Centre address:</td>
<td>Sallins Road, Naas, Kildare.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>045 874 700</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:milllanemanor@brindleyhealthcare.ie">milllanemanor@brindleyhealthcare.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>A Nursing Home as per Health (Nursing Homes) Act 1990</td>
</tr>
<tr>
<td>Registered provider:</td>
<td>The Brindley Manor Federation of Nursing Homes Unlimited Company</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Amanda Torrens</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Leone Ewings</td>
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<tr>
<td>Support inspector(s):</td>
<td>Gearoid Harrahill</td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>61</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>9</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).
This inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration renewal decision. This monitoring inspection was un-announced and took place over 1 day(s).

**The inspection took place over the following dates and times**
From: 24 August 2017 10:00  
To: 24 August 2017 20:00

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>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Non Compliant - Moderate</td>
<td>Compliant</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Substantially Compliant</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Substantially Compliant</td>
<td>Compliant</td>
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<tr>
<td>Outcome 06: Safe and Suitable Premises</td>
<td>Substantially Compliant</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td></td>
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<td>Outcome 08: Governance and Management</td>
<td></td>
<td>Compliant</td>
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<tr>
<td>Outcome 12: Notification of Incidents</td>
<td></td>
<td>Substantially Compliant</td>
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</table>

**Summary of findings from this inspection**
The application for renewal of registration received from the provider was reviewed and part of this inspection process. This inspection was also to determine what life was like for residents with dementia living in the centre. Care practices and interactions between staff and residents who had dementia were observed and scored using a validated observation tool. The inspection focused on the six outcomes and also two further outcomes were also included; governance and management and health and safety and risk management. Unsolicited information and notifications received were also considered as part of this inspection.
Nineteen residents in the centre had been assessed as having a diagnosis of cognitive impairment, Alzheimer's disease or dementia. The centre did not have a dementia specific unit, and the centre was laid out over two floors. Inspectors were informed that one resident was in hospital at the time of the inspection. Prior to this inspection the provider had been requested to complete a self-assessment document and review relevant polices. The judgments in the self assessment stated all but one outcome were in compliance or in substantial compliance with the regulations. The provider had assessed that premises was a moderate non-compliance, and was implementing a plan to address improvements identified.

The inspectors found that the centre met the individual care needs of residents with dementia and operated in line with the statement of purpose. Information was available for residents and relatives about dementia and residents' healthcare needs were met. Responsive behaviours were well managed by staff and staff training was in place.

The staffing in place and skill-mix met the needs of residents. Staff had received training which equipped them to care for residents who had dementia. Staff were kind and respectful and staff were available in a timely manner to residents and relatives. Residents with dementia had their choices in relation to all aspects of their daily lives respected by staff. Nonetheless, improvements were required in terms of staff communication with people with dementia, provision of meaningful activities, records of activity maintained and records of nursing care related to pressure ulcer prevention and management. Inspectors found that some areas reviewed required review by the provider and person in charge in terms of premises; notification of incidents and record-keeping. Action plans can be found at the end of this report.
Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National 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 was judged to be substantially compliant in the self-assessment, the inspectors concurred with this judgment.

Overall the care and welfare of residents with a diagnosis of dementia, Alzheimer's and those with cognitive impairments was being well met. The nursing, medical and social care needs of these residents were found to be of a good standard. Residents' confirmed their wellbeing to the inspector during the inspection. Residents with dementia had their choices in relation to aspects of their daily lives respected by staff. Staff communicated in a person-centred way to promote independence and autonomy of the people living at the centre.

There was an admissions, transfers and discharge policy in place, which involved assessing the cognitive abilities prior to a long-term admission. Records of a multi-disciplinary assessment and suitability for accommodation and the environment took place prior to each potential admission. Records included details of residents who had been transferred into and out of hospital, with details of any transfer letters from the centre to the acute hospital on file, together with nursing and medical transfer letters from the acute hospital back to the centre.

Community involvement and retaining autonomy and any existing links following admission to the centre was promoted by staff. A system to record resident inputs and consultation regarding care plans was in place.

Residents had access to medical and allied health care professionals. Evidence was seen that general practitioner's (GP's) visited the centre to see residents regularly. Access to out-of-hours and on-call medical care was also fully facilitated. Where required, some residents had access to a consultant psychiatrist and other acute hospital consultant referrals. Referrals for residents for assessment to any of the allied health care team members was timely, and documented to inform and update care planning.

Staff facilitated residents to have routine assessments of eyesight, audiology and dental
needs. There was clear evidence that all residents had their medical needs including their medicines reviewed by the pharmacist, GP and nursing staff. The pharmacist delivered medicines to the centre as required and provided audit, support and training as required. Records of prescribed medicines and those administered were clear and found to be fully in line with the centre's medication policy.

Risk assessments and care plans were reviewed on a three-monthly basis and those reviewed reflected the residents' changing needs. Each identified need had a care plan in place, reflecting the care required by the resident in order to meet that need. Assessments and care plans were updated on a three-monthly basis. A sample of care plans reviews read by the inspectors were up-to-date.

Staff provided end-of-life care for residents with the support of the general practitioner and the palliative care team if required. Each resident had their end-of-life preferences recorded and a detailed end-of-life care plan in place. These care plans addressed the resident's physical, emotional, social and spiritual needs. They reflected each resident's wishes and preferred pathway at end-of-life. They were detailed and included input from the resident and their next of kin.

Overall the nutritional needs of residents were met and they were supported to enjoy the social aspects of dining. Residents could dine in a place of their choice including in their own rooms. The menu provided a choice of meals to residents, and residents' likes and dislikes were respected.

Residents had a malnutrition risk screening tool (MUST) completed on admission and this was reviewed three monthly. Residents' weights were recorded and had their body mass index calculated on a monthly basis. Those with any identified nutritional care needs had a nutritional care plan in place. Nursing assessments for any resident identified as at risk of malnutrition triggered a referral to a dietician. The inspectors saw that residents' individual likes, dislikes and special diets were all recorded and were known to both care and catering staff.

A physiotherapist and occupational therapist (OT) were part of the staff team in the centre. Referrals could be made to both staff members and they were found to work as part of the multi-disciplinary team. The occupational therapies undertook seating assessments and made recommendations about suitable seating. Nonetheless, inspectors saw that one resident was seated in a tilted seat which did not fully meet this resident's needs. The occupational therapist confirmed that a seating assessment and had not yet taken place, but this would be fully reviewed to assess for suitable seating. Both the physiotherapist and OT were currently involved in the social programme as outlined in Outcome 3 of this report, records maintained of resident attendance, level of interest and participation required some improvement.

Inspectors were informed that four residents had pressure ulcers being treated. Wound assessments and care plans were in place to guide staff in evidence-based practice. The records were reflective of care provided, including records of tissue viability specialist inputs. Pressure ulcer prevention and management practice was found to be adequate, and all staff were knowledgeable and well informed about skin care and prevention with policy implemented. However, some of the sample records reviewed required
improvement relating to the daily nursing narrative, specific to the residents' skin condition. Details of grading of pressure ulcers was not consistently documented to guide practice. The provider confirmed to inspectors that further training would be planned to take place for staff in this aspect.

Judgment:
Substantially Compliant

### 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:
This outcome was judged to be a moderate non-compliance in the provider's self assessment, and the inspectors judged it as compliant. The records of resident finances were not reviewed at the time of this inspection.

The inspectors found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse. Two safeguarding reports had been made since the last inspection and the actions taken further communicated to HIQA. Final reports were not yet submitted but both had been investigated by the person in charge. All residents were found to have been appropriately safeguarded at all times by the provider and the person in charge. Measures put in place included increased staff supervision measures, which were ongoing at the time of the inspection.

The approach used by all staff demonstrated a good standard of a consent-led service provision. Elements of good practice to safeguard residents' privacy and dignity and rights were observed during this inspection.

There was an up to date safeguarding policy in place. The inspectors spoke with a number of staff members who were clear on what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about resident safety or wellbeing.

All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. They also spoke highly of the care provided by the staff and their caring attitude, and a person-centred approach.

At the time of the inspection, a small number of residents presented with some mild responsive behaviours. These were generally well managed by staff. Residents who required support had an assessment completed and care plans were developed that set
out how residents should be supported if they had any responsive behaviours. The inspectors saw that they described the ways residents may respond in certain circumstances, and that action should be taken, including how to avoid the situation escalating. For example, using a low arousal or an individualised sensory approach. Staff spoken with were clear about how to manage and re-direct each resident. Staff also considered how residents were responding to their environment and were supporting people to feel calm. For example, a new area called the butterfly room had come in to use over the last few months, as a quieter space. Residents who also needed additional supports or increased supervision could be accommodated in this area but were also free to move about the centre if desired. The layout and design of the ground floor supported those who wished to take walks both indoors and outdoors.

Evidence-based policies in place about responsive behaviours (also known as behavioural and psychological signs and symptoms of dementia) and a policy on restraint was in place. The inspectors were informed by the staff that they had training in how to support and communicate with residents with dementia. Training records read confirmed that staff had attended training on dementia awareness.

There was a clear written policy on any restrictive practices which may be considered for use in the centre. The policy, practice and assessment forms reviewed reflected practice that was in line with national policy, as outlined in Towards a Restraint Free Environment in Nursing Homes (2011). A small number of residents were found to be using bedrails at the time of the inspection. Alternatives to the use of bedrails were available, considered and documented. For example, increased staff supervision measures, low-low beds, sensor alarms and crash mats. The records of residents receiving any prn (as required) psychotropic medicines for responsive behaviours were reviewed by inspectors. Overall, there was clear evidence of review. Where required a detailed behavioural support plan had been developed and was in place to inform staff.

**Judgment:**
Compliant

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

**Theme:**
Person-centred care and support

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

**Findings:**
This outcome was judged to be a substantially compliant in the provider's self assessment, and the inspectors judged it as substantially compliant.

At the time of inspection, the activities coordinator post had been vacant for a number of weeks whilst recruitment was ongoing. The provider confirmed that a new activities
coordinator was due to start in this role. Interim measures to meet residents' social and recreation needs were in place. The occupational therapist and the physiotherapist on-site were sharing the role of activities coordinator in addition to their main roles. In doing so, this had retained the continuity of activities residents enjoyed both in and out of the centre. For example, weekly attendance of a number of residents to a local community choir, retaining valuable links with the local area outside the centre. The social breakfast sessions continued, and other group sessions such as baking and reminiscence therapy. Some activities could combine with the duties of their primary role, such as exercise sessions. Time to undertake one-to-one activities with residents who choose not to participate in group activities or lacked the capacity to do so was limited. They also did not have time to track attendance, level of interest and participation to establish which residents were going for extended periods of time with no meaningful activity or recreation. The centre also utilised social care facilitators, who were tasked with assistance of residents outside of the personal or intimate care delivered by healthcare assistants.

Residents spoken with said that they did always not know what activities were happening in the centre. Inspectors found that scheduled and planned activity did not currently always take place. A number of in-house satisfaction surveys by residents and relatives expressed that they did not know what activities took place, or that they were unhappy with the amount of activities available in the centre, finding the day long as a result. There was an activities board posted in the main lobby of the centre but at the start of the day nothing was posted on it besides the daily social breakfast session. Later a poster was added to the board about reminiscence therapy in the afternoon, and later in the afternoon a schedule for the current week was posted. This schedule was also presented by management to inspectors for the previous and following week. However staff were not always clear on what activities were occurring in the centre.

The occupational therapist was observed hosting a reminiscence therapy session with a small group of residents which was received well, the group card games listed on the same schedule for the afternoon were not seen happening in any of the communal areas on or after the time listed. The main communal living space lacked any incidental opportunities for recreation such as the availability of board games, cards, newspapers, magazines or puzzles.

As part of this inspection, the two inspectors spent approximately 45 minutes each observing interactions between staff and residents. While interactions between staff and residents were friendly, respectful and patient, they were primarily task-oriented. Conversation rarely strayed beyond the task at hand such as serving tea or being assisted to mobilise. A minority of conversations discussed topics which had personal meaning to the resident. From a dementia friendly interaction perspective, a number of instances were observed of staff addressing residents without first establishing their attention, such as speaking to residents while coming up behind them, not engaging eye contact, or standing over the resident while they spoke. Some residents were observed going for extended periods of time with no interaction, stimulation or entertainment, unless they required immediate assistance from staff.

Good practice was seen around affording residents privacy and dignity, such as knocking before entering bedrooms and explaining what was happening before assisting residents
to stand or transfer. Nonetheless, in terms of communication a small number of staff were heard by inspectors to address residents with generic terms such as "love", "my dear", or "pet". While this adds to the friendly nature of interactions, it should not be encouraged as a culture as the sole or primary means of addressing residents instead of using their names. This was discussed at the feedback meeting and the provider and management team undertook to review and improve in this area with staff.

The centre has held regular resident forum meetings, matters discussed included planning for future day trips or seasonal events. Meetings were chaired by an external advocate, and minutes of these are noted as being followed up on a later date. Residents and relatives had also completed in-house satisfaction surveys, and management had added notes on major or recurring points of positive or negative feedback, for example the catering and meal time experience. In the provider’s self assessment, an action was the introduction of simple pictorial flashcards, which were shown to inspectors and advised that they had been a valuable aid in communicating with residents with reduced cognition or who did not have English as a first language.

Residents were registered to vote, and fortnightly mass was held on the premises, with weekly visits from a Eucharistic minister. Residents were well facilitated to retain links to the world outside the centre. As referred to previously, weekly participation in a local community choir was facilitated and encouraged. Some residents were observed chatting on the phone and they centre had wireless internet to allow residents to watch television online or make video calls to family and friends.

**Judgment:**
Substantially Compliant

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**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:**
The provider self-assessment had stated that there was substantial compliance and further training and information was required to ensure all residents, relatives and staff were fully aware of the complaints policy and procedure to follow.

Inspectors found a clear complaint’s procedure and a complaint’s policy was in place that guided practice. The person in charge was the person nominated to deal with all complaints and ensure that they are fully investigated. The complaint’s procedure was displayed prominently and was in line with the information within the complaint's policy. The policy listed the various contacts relating to making a complaint, the process for appealing the outcome of a complaint and clearly differentiated between which contact
was involved in the initial complaint and which contact should be contacted to appeal the outcome of a complaint.

The process confirmed by the inspector was that in the first instance the nurse on duty would try to resolve the issue, and the person in charge as complaints manager would then follow the policy. An appeals process was in the policy and outlined also in the resident’s guide. The right for a complainant to access the ombudsman was also clearly outlined.

There had been one written complaint recorded since the last inspection as confirmed by the provider, this was found to be in an investigation process by the operations and compliance manager, who was present in the centre at the time of the inspection. However, a final investigation and outcome was not yet completed for this complaint, nor had the review concluded to inform the complainant of the outcome. The provider and operations and compliance manager confirmed that this was in progress and in due course the records would be completed and complainant communicated with the outcome.

**Judgment:**
Compliant

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**Outcome 05: Suitable Staffing**

**Theme:**
Workforce

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

**Findings:**
This outcome was judged to be substantially compliant in the self-assessment, the inspectors judged it as in full compliance. The provider had identified a need to appoint two senior health care assistants and this has now taken place. The two new staff members had been recruited into this role to improve supervision.

Nursing staff were rostered in the centre during the day and night. All nurses working in the centre had confirmation of their current registration with the Nursing and Midwifery Board of Ireland for 2017 documented. All staff were found to be responding in a timely way to residents' needs, and any call bells were answered promptly on the day of the inspection.

All staff were up to date on training in fire safety, manual handling and safeguarding of vulnerable adults. Staff had been trained in a positive approaches to dementia care model. Further training dates were scheduled to be delivered, as an ongoing programme with more staff as part of the 2017 training plan. Supplementary training such as food and nutrition, wound care, continence care and cardio-pulmonary resuscitation was also
planned for. All staff spoken with or observed were familiar with procedures in the centre around responding to alleged or suspected abuse incidents, and what to do if the fire alarm were to activate.

Inspectors reviewed a selection of personnel files and found them to contain all documentation and vetting information required under Schedule 2 of the regulations. The centre did not utilise any external agency staff or volunteer staff. Staff meetings were held in the centre and staff spoken to were familiar with their role and to whom they would report any issues. Recruitment was almost completed for a new activities coordinator at the centre due to start work the following week.

**Judgment:**
Compliant

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

**Findings:**
The provider had judged this outcome as being in substantial compliance, and the inspectors concurred with this judgment.

The design and layout of the building was suitable for the number and needs of the residents in the centre, and was found to be overall clean, well heated and in a good state of repair. In the provider's self assessment, the action was planned to introduce assistive signage to the premises. This had been achieved with doors and corridors having simple and eye-catching pictorial signage and arrows directing residents to the dining room, living room, nearest toilet, or nearest evacuation route. There was evidence of an ongoing maintenance programme in place for the upkeep of the building. For example, upgrading of flooring and decoration and painting of walls.

The building comprised of mainly single and nine double occupancy rooms over two storeys. Bedrooms were of a suitable size and were decorated to the residents' preferences. Rooms accommodating more than one resident had appropriate privacy screening between the bed spaces, and all bedrooms had en-suite toilet and shower facilities and these were equipped with grab rails, wetroom flooring and bathroom ware at an appropriate level to be suitable for residents with reduced mobility or who used a wheelchair. An up-to-date insurance policy was in place for the centre which included cover for residents' personal property, and accident or injury to residents in compliance with the requirements of the regulations.

The front of the centre had a large open plan communal day room and reception area,
which was suitably decorated with space for activities and visitors. For residents with higher dependency or in need of a quieter space there was a smaller sitting room available. This sitting room also had a sun room adjacent, the provider advised that over the last few months this area was developing with people with dementia in mind. A member of the groups staff had visited and made recommendations in terms of making this room more dementia-friendly. The room was large and open and on the day of the inspection accommodated comfortably the six residents observed during the time spent in this room. Locally this room was now known as the butterfly room and there was adequate space for residents to comfortably move around and visit the sunroom which was furnished with table and chairs. Inspectors suggested that an area for improvement would be with the contrast and colours of the seating and flooring, and to review the lighting as shadows were observed with the current style of light fittings in place, and natural lighting could be improved by reviewing the curtains in place to allow more light in.

The centre had an oratory, hairdressing salon, and dining room suitable for the number and needs of the residents. Call bells were available in all bedrooms, bathrooms and communal zones. There were adequate toilet and bath facilities in place. Storage of equipment was in need of review as inspectors observed linen trolleys and hoists being stored in a large assisted bathroom nearest the day space.

From the perspective of dementia-friendly design layout of the corridors on the ground and upper storeys were designed in a large, simple circuit, which would allow a resident to stroll around the centre and returning to the main communal hub without coming to a dead end or an obstruction. The corridors were wide enough to use assistive equipment, lined with suitable handrails and free of trip hazards, steps and other physical barriers obstructing navigation. Inspectors observed some residents who propelled themselves in wheelchairs to have some minor difficulty getting over the lip of external doors and the provider is considering their options for making it easier to traverse without affecting the fire safety nature of the doors. Each bedroom had the resident's name clearly displayed along with pictures or photos of places and objects which had meaning to the resident.

The centre made good use of external space, having large internal courtyards which were safe and appropriately enclosed, which allowed doors leading to these to be kept open and so encouraged their use as a place to sit outside on garden furniture or to use as part of a walk around the premises. One of the courtyards had an external smoking shelter and seating which was equipped with metal ashtrays, aprons and a fire extinguisher, and was visible from the main communal area by staff.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support
Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The centre maintained a safety statement and risk register which were specific to the centre and up-to-date. No risks was identified during this inspection.

An evacuation plan was available and posted in the corridors and lobby. Illuminated signage and fire maps with the most efficient evacuation route marked were posted prominently in the centre. The centre also had in place a personal emergency evacuation plan (PEEP) which denoted each resident’s ability and assistive equipment needs to evacuate in the event of an emergency, and staff were familiar with where this was found.

Staff across all categories were up to date in their mandatory fire safety training and staff asked were familiar with their role in the event of a fire alarm trigger. Fire drills had been held on both day and night in the centre. The reports from these identified the staff involved, the residents in the zone who were evacuated, the time taken to do so and notes on delays and incorrect practice which could serve as learning towards more efficient evacuation. Certification and proof of external testing and servicing was available for the fire alarm system, fire fighting equipment, emergency lighting and flame resistant materials and upholstery.

Cleaning staff were confident in their knowledge of cleaning procedures and practices and how information was communicated to them by the care staff and management. A small number of bedrooms had been identified as an infection control risk, and were equipped with stations of personal protection equipment. For example, gowns, gloves and aprons for staff. Staff were also clear on the changes to their routine made if there was an outbreak in the centre or if dealing with spill of any kind.

Overall, falls and any incidents were well managed, and reported in line with requirements. Nonetheless, the inspectors noted that a small number of three day notifications had been returned late, and that a rationale for the delay was around the use of e-mail service at the centre. The provider and person responsible for submitting gave assurances that this would be monitored more closely to ensure full compliance with reporting requirements as this had been a previous non-compliance.

Judgment:
Compliant

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:
There is a clearly defined management structure which identifies the lines of authority and accountability, as outlined in the statement of purpose. At the time of this unannounced inspection the inspectors were shown a copy of a notification from the provider, submitted the day before, informing HIQA that the person in charge would be off-duty for more than 28 days. The provider outlined the current arrangements in place to inspectors and was present throughout the day. The person responsible in her absence as person in charge was the quality and compliance manager. Staff rosters confirmed he would work full-time in the centre, to cover the absence of the person in charge. He will be supported by the assistant director of nursing day-to-day in the centre.

Management meetings took place as part of the clinical governance group, which includes senior staff from the group's other centres. The provider confirmed this group meets regularly to review and monitor quality of care, incidents and review any identified risks. Systems were in place including audit tools to review quality and safety of care, including, medicines management, falls, hygiene and maintenance of the premises. Administration staff supports were in place including reception staff during the day.

Judgment:
Compliant

Outcome 12: Notification of Incidents

Theme:
Effective care and support

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

Findings:
A three day notification had been returned late, and that a rationale for the delay was around the use of e-mail service at the centre. One further notification had not been submitted but was notified to HIQA in the days following the inspection.

The provider and person responsible for submitting gave assurances to the inspectors that this would be monitored more closely to ensure full compliance with reporting requirements.

Judgment:
Substantially Compliant
Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Leone Ewings
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Outcome 01: Health and Social Care Needs

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Records reviewed required improvement relating to the daily nursing narrative specific to the residents' skin condition and details of grading of pressure ulcers. Records of attendance at activities, and details of the level of interest and participation were not fully maintained.

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 21(1) you are required to: Ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.

Please state the actions you have taken or are planning to take:
The Director of Nursing has developed a guide for the nursing team to enhance and improve narratives specific to areas identified by the inspectors of which the ADON will review periodically. 18th September 2017
Further assistance and support has been focussed to crutch the staff nurse team in relation to wound documentation and guidelines have been set for the B-Fit team. 18th September 2017
A training programme in wound care management is scheduled to assist staff nurses in appropriate narratives and further education. 30th October 2017

Proposed Timescale: 18th September 2017 & 30th October 2017

Proposed Timescale: 30/10/2017

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:
Information for residents to attend and participate in activities being held in the centre was absent, inconsistent or unclear.
Activity provision in the butterfly room was limited to listening to the radio during the period of observation.

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

Please state the actions you have taken or are planning to take:
The Director of Nursing has set guidelines for the B-Fit team individually on daily, weekly and three monthly basis. Activity plans are now insitu and posters relating to same are visible throughout the home. A full review of the activity provision within the Butterfly room has been reviewed as has been throughout the home in general and improvements have been implemented.

Proposed Timescale: 18/09/2017
Theme:
Person-centred care and support
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff communication and use of some terms of address were not always commensurate with adulthood.
Staff supervision and training in communication techniques in care delivery with residents needed review.

3. Action Required:
Under Regulation 10(3) you are required to: Inform staff of any specialist needs referred to in Regulation 10(2).

Please state the actions you have taken or are planning to take:
The Person In Charge has spoken to all staff around the observation of staff communication as advised by the inspectors. The staff team on consideration of the comments have introduced a “culture box” where contributions must be made by a staff member breaching this rule and the contents of this box will be lodged to the Mill Lane Manor Residents Fund. 18th September 2017 and ongoing.
The Person In Charge has organised additional training for the staff team to assist them in daily communication techniques. 20th October 2017.

Proposed Timescale: 18th September 2017 & 20th October 2017

Proposed Timescale: 20/10/2017

Outcome 06: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Storage of equipment including linen trolleys and hoists in assisted bathroom was inappropriate.

4. Action Required:
Under Regulation 17(2) you are required to: Provide premises which conform to the matters set out in Schedule 6, having regard to the needs of the residents of the designated centre.

Please state the actions you have taken or are planning to take:
Storage of equipment within the home has been addressed and staff have been reminded at each handover of the appropriate storage of equipment.
**Proposed Timescale:** 18/09/2017

**Theme:**
Effective care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The butterfly sitting room required review in terms of suitable dementia friendly lighting and provision of suitable seating contrasting with the colour of the flooring in this space.

**5. 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:
Following a management review of the opinions of the inspectors on the day of inspection, the Butterfly Room has been relocated within the nursing home.

**Proposed Timescale:** 18/09/2017

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**Outcome 12: Notification of Incidents**

**Theme:**
Effective care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Management systems in place for submission of three-day notifications were not adequate.

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

Please state the actions you have taken or are planning to take:
The Person in Charge is fully aware of the obligations around Regulation 31(1) set out in paragraphs 7(1)(a) to (J) of Schedule 4 in relation to submission of three day notifications.

**Proposed Timescale:** 25/08/2017