

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Ballinamore House Nursing Home
Centre ID:	OSV-0000317
Centre address:	Ballinamore, Kiltimagh, Mayo.
Telephone number:	094 938 1919
Email address:	ballinamorehouse@hotmail.com
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Raicam Holdings Limited
Provider Nominee:	Sharon O' Boyle
Lead inspector:	Mary McCann
Support inspector(s):	Brid McGoldrick; Niall Whelton (Day 1)
Type of inspection	Announced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	8

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- **Registration:** under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- **Monitoring of compliance:** the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- to carry out thematic inspections in respect of specific outcomes
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or wellbeing of residents.

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. In contrast, thematic inspections focus in detail on one or more outcomes. This focused approach facilitates services to continuously improve and achieve improved outcomes for residents of designated centres.

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 inform a registration renewal decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
20 September 2017 10:30	20 September 2017 19:30
21 September 2017 08:30	21 September 2017 15:30

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	Substantially Compliant
Outcome 02: Governance and Management	Non Compliant - Moderate
Outcome 03: Information for residents	Substantially Compliant
Outcome 04: Suitable Person in Charge	Compliant
Outcome 05: Documentation to be kept at a designated centre	Substantially Compliant
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Major
Outcome 09: Medication Management	Compliant
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Moderate
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Compliant
Outcome 15: Food and Nutrition	Compliant
Outcome 16: Residents' Rights, Dignity and Consultation	Non Compliant - Moderate
Outcome 17: Residents' clothing and personal property and possessions	Substantially Compliant
Outcome 18: Suitable Staffing	Compliant

Summary of findings from this inspection

This inspection was an announced monitoring inspection the purpose of which was to inform a decision regarding the renewal of a registration following an application made by the provider and to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Standards for Residential Care Settings for Older People in Ireland.

There were 34 residents in the centre. The centre is registered to provide care to a maximum of 42 residents.

Notifications of incidents and information received by the Authority since the previous inspections of January and May 2017 were followed up on at this inspection. The previous inspection referred to in this report with regard to actions is January 2017 as the inspection report of the inspection carried out in May 2017 has not been finalised.

Inspectors met with residents and staff members, observed practices and reviewed documentation such as care plans, medical records, clinical and environmental audits, policies, procedures, risk management documentation and contracts of care as part of the inspection process.

Inspectors wish to acknowledge the work that the provider representative has undertaken since the last inspection which includes thumb action locks on toilet doors, completion of regular fire drills, upgrading of bathroom, showers and toilets, reconfiguration of room 7, installation of an LS1 fire alarm system, commencement of a review of electrical installation, completion of an annual review. Some of these areas were in process and required further work post this inspection and the provider gave a firm commitment to continue to address these areas.

Seven residents and 15 relatives completed a pre-inspection questionnaire. On review of these inspectors found that residents and relatives were positive in their feedback and expressed satisfaction about the service, and care provided. They were complimentary of the staff and made statements such as "I get a warm welcome no matter what time I go at, my relative is very well cared for, staff are caring patient and compassionate, the centre is always very well staffed, my relative can get up when it suits him and do what he wants during the day, they are always doing different activities, skittles, arts and crafts, painting exercises, walks if weather is good, I'm glad I came in, I know I am safe in here, I have never had reason to complain, staff are very good at caring for me, the food is good and we get plenty of it". Residents who could verbalise their views were complimentary about their day to day life experiences, the meals provided and the staff team.

Inspectors found that there were issues of non compliance in relation to the design and layout of areas of the premises as regards the legislative requirement to protect and promote the privacy and dignity of residents. The provider representative had reconfigured room seven. Inspectors spoke with the provider representative with regard to reconfiguring room one and she gave a verbal commitment that the occupancy of this room would be two high dependency residents and two residents who were weight bearing or required the assistance of one person for mobilising. This would be based on completion of a mobility assessment. The provider representative agreed to submit a drawing of the reconfiguration of both rooms once completed. Suitability of these rooms together with their impact on privacy and dignity of residents is detailed in the inspection report of the 24 May 2017.

Eighteen outcomes were inspected and nine actions were reviewed from the January 2017 inspection to monitor progress. Eight actions were complete. One action with

regard to completion of quality improvement plans post audits had not been addressed. The action with regard to completion of an annual review of the quality and safety of care provided to residents required further input. Of the 18 outcomes inspected nine were compliant, four were substantially compliant, four were moderately non compliant and one was deemed to be a major non-compliance. Outcomes with regard to health and safety and risk management were deemed to be major non-compliant.

Improvements required post this inspection include:

Completion of a fire safety review and enactment of any measures recommended by specialist fire personnel.

Safe storage of oxygen and erection of signage to alert personnel of its storage for safety reasons.

Make provision that assistive equipment required to meet residents needs for example weighing equipment so that all residents may be weighed.

Ensure that where residents are admitted with specific nutritional needs for example impaired swallowing that these needs are clearly communicated to the centre and are documented in the residents' clinical records on admission.

Where residents are utilising supportive/specialist chairs that occupational therapy assessments have been completed to ensure these chairs are appropriate and safe for use by residents. These to be reviewed according to changing needs.

A robust procedure to be put in place with regard to communication of residents' specialist and preferred nutritional needs to catering staff.

Completion of continence and communication assessments on residents post admission and enactment of care plans if required.

Training for staff in evidence-based practice in infection control

further review of the annual review of the quality and safety of care delivered to residents.

Ensuring that where meetings occur or where audits are completed that the results are reviewed and analysed and a quality improvement plan is enacted that shows the deficit to be addressed, who is responsible for this action and a timeline is documented with regard to enactment.

Review and enhancement of the physical environment to ensure that assistive aids such as handrails are in place at slops or inclines to promote safety and enhance the independence of residents, ensuring care is provided in line with best practice in dementia care and design

Amendment to policies and procedures and template documents to ensure they are centre specific to ensure they guide and inform staff in the delivery of safe quality care

Review of clinical and domestic waste management

Completion of an accessible residents guide

These and further areas for improvement are discussed throughout the report and are included in the action plan 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: Statement of Purpose

There is a written statement of purpose that accurately describes the service that is provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Inspectors reviewed the statement of purpose, which had been updated since the last inspection. It outlined the ethos and aims of the centre. While it contained all the matters as per Schedule 1 of the Regulations, there was not adequate detail in some areas for example, fire safety and emergency procedures. Review is required to ensure it describes the service provided in detail and how it is to be provided to include the layout of the premises where residents are accommodated and facilities that are provided.

Judgment:

Substantially Compliant

Outcome 02: Governance and Management

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

Theme:

Governance, Leadership and Management

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

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

Findings:

Inspectors found that the current governance and management structure does not ensure the effective delivery of care to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This judgment is based on the cumulative findings of this inspection and non-compliances found in relation to poor risk identification, fire safety and the lack of auditing with a view to improving the service

and ensuring positive outcomes for residents. Competence with regard to capability and capacity to address regulatory breaches and ensure the delivery of safe quality care to residents will be reviewed on each inspection.

While an annual review of the quality and safety of care delivered to residents was completed for 2016 this required further input to ensure that it was used as way of seeking to improve the quality and safety of care provided. No quality improvement plan had been developed post completion of this report. There was a paragraph entitled 'Vision for 2017' which stated "we will strive to continue our excellent resident centred care and homely atmosphere.'

Environmental and clinical risks were identified by the inspectors that had not been identified in audits completed by the provider representative/person in charge. These related to potential risks to residents including fire safety, the ramp at the rear of the dining room, waste management not appropriately managed, as the clinical waste was not secured and domestic waste bins were overflowing. A robust decontamination programme for equipment used by residents was not in place and a monitoring system for water testing and vents to minimise the potential spread of healthcare associated infections was not in place.

Inspectors were informed that an oxygen cylinder was stored in the former church area, this could not be found by the provider or inspectors on the morning of the first day of inspection. The provider informed the inspectors in the evening of the first day of inspection that this had been located. There were no signs in place indicating that oxygen was stored in this area and the way it was stored was not safe due to the risk of combustion should a fire occur.

No risk assessment was made available to inspectors with regard to the safe storage of gloves and aprons. Where residents who are cognitively impaired or have a diagnosis of dementia there may be at risk of ingesting gloves and choking.

The list for informing catering staff as to the type of special diet a resident was to receive was not up to date. This posed a risk to residents of getting the wrong consistency of food according to their assessed needs.

Minutes of weekly meetings were available between the provider and person in charge. However no agenda was available for these meetings and no action plan was developed for any issues identified.

A management structure that identified the lines of authority and accountability for nursing, care, laundry and catering staff was in place. Maintenance personnel reported to the provider and person in charge. The provider representative works full-time in the centre and is identified as the person participating in the management of the centre on the application for renewal of registration.

The provider representative displayed a positive attitude to addressing breaches of the regulations identified. She stated she was committed to providing a good service and had implemented some positive measures since the last inspection. Throughout the inspection issues that were brought to her attention with regard to fire safety, she immediately sought to address by arranging specialist personnel to attend the centre.

The provider stated that she had arranged for the delivery of a shed to store many tins of paint that was stored inappropriately in the former church area. Inspectors were concerned as there were fire safety issues to be addressed in this area and with the storage of this paint, should a fire occur it would be a contributory factor to toxic fumes. The provider agreed to increase staff surveillance at night time in the area where fire safety was noted to be of concern.

Good practices were identified with regard to communication between nursing staff as a daily comprehensive handover was in place where a detailed discussion took place with regard to any changes in clinical status of residents.

Judgment:

Non Compliant - Moderate

Outcome 03: Information for residents

A guide in respect of the centre is available to residents. Each resident has an agreed written contract which includes details of the services to be provided for that resident and the fees to be charged.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

A residents' guide was made available to the inspectors at the time of inspection. On review this was found to contain all of the information required by the Regulations however it was not accessible to residents with dementia or cognitive impairment. An accessible version was required.

A sample of residents' contracts of care was reviewed by the inspectors. These had been agreed on admission. They set out all fees being charged to the resident and all services to be provided. No extra fees for social care/ physiotherapy.

The contract of care specified whether the bedroom to be occupied was single, twin or multi occupancy as required by the 2016 regulations.

Judgment:

Substantially Compliant

Outcome 04: Suitable Person in Charge

The designated centre is managed by a suitably qualified and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The person in charge worked full-time and generally worked from 08:00 hrs to 16:00 hrs Monday to Friday, according to the rota provided to inspectors. She qualified as a registered general nurse in 1997. She was appointed person in charge of this centre in 2008. Inspectors reviewed the duty roster and found that a registered nurse was always on duty in addition to the person in to ensure she had adequate time for governance supervision and management duties. Her current registration with An Bord Altranais agus Cnáimhseachais na hÉireann registration was available.

She confirmed that the provider was supportive and was freely available to her. Residents spoken with knew the person in charge. Courses completed since the last inspection included short courses in dementia care, health and safety, safeguarding and basic life support.

Judgment:

Compliant

*Outcome 05: Documentation to be kept at a designated centre
The records listed in Schedules 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.*

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

Records listed in Schedules 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 (as amended) were available. Inspectors reviewed a sample of these records to include fire safety, staff recruitment and residents' care and medical files.

Fire safety records were incomplete as detailed under outcome 8.

Certificates for the emergency lighting system were not available.

Some records were incomplete for example cleaning rosters for toilets. Some records were not up to date for example, the list of specialist diets and feeding guidelines for

residents.

Communication and continence assessments required reviewed to ensure they were more comprehensive and they enhanced the independence of residents.

A sample of staff files was reviewed and found to be compliant with the regulations. The provider confirmed in writing to the authority on the 26 September 2017 to confirm that all staff employed to work in the centre have current and up to date Garda Vetting and no volunteers were currently working in the centre.

The centre's insurance was up to date and provided adequate cover for accidents or injury to residents, staff and visitors.

A record of visitors was maintained. The directory of residents' contained all information required by schedule three of the regulations and was maintained up to date.

Approved operational policies were not implemented in practice to ensure resident and staff health and safety, identify and manage risks for example with regard to fire safety, food and nutrition and infection control.

Judgment:

Substantially Compliant

*Outcome 06: Absence of the Person in charge
The Chief Inspector is notified of the proposed absence of the person in charge from the designed centre and the arrangements in place for the management of the designated centre during his/her absence.*

Theme:

Governance, Leadership and Management

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

No actions were required from the previous inspection.

Findings:

The provider representative works full-time in the centre and is identified as the person participating in the management of the centre on the application for renewal of registration. She is a registered nurse and deputises for the person in charge in her absence. Her registration with An Bord Altranais was up to date. When the provider representative and person in charge are not on duty an assistant director of nursing was available. An on-call management rota was in place.

Judgment:

Compliant

*Outcome 07: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are provided with support that promotes a*

positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Measures were in place to protect residents from being harmed or suffering abuse. Staff had been provided with training in recognising and responding to elder abuse. The person in charge had attended training on safeguarding vulnerable adults at risk of abuse and was the dedicated reporting person for the centre. Staff spoken with were clear on their role and responsibilities in relation to reporting abuse. All stated they would report any concern they had with regard to safeguarding to the most senior person on duty at the time.

In discussion with the assistant director of nursing on the use of bedrails she described how most were used as an enabling function, with many having been requested and others were in place for the purpose of positioning or enhancing the residents' function. Care plans were in place detailing the rationale for use of the bed rails. Records indicated that restraint was only used following a safety risk assessment. There was a policy on the management of responsive behaviour. The person in charge stated that while a small number of residents presented with responsive behaviour, there were no residents who were currently displaying responsive behaviour. Positive behaviour support plans were in place to provide direction to staff as to how to manage responsive behaviour. This was an action from the January 2017 inspection. There was good access to the psychiatry of later life services.

Resident's finances were not checked on this inspection. This was inspected in January 2017. The provider representative acts as an agent for one person, she has confirmed to HIQA that she has been appointed by the department of social protection as an agent for this resident and that the next of kin is aware of this arrangement.

Judgment:

Compliant

*Outcome 08: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.*

Theme:

Safe care and support

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

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found that improvement was required in taking adequate precautions against the risk of fire.

With respect to the centre from a fire safety perspective, inspectors reviewed the fire safety management practices in place, including the physical fire safety features of the building. The building was reviewed in the presence of the Provider representative. Inspectors also examined records for maintenance, fire safety training of staff, evacuation procedures and programme of drills. Inspectors noted a positive and proactive response from the provider during the inspection to all fire related matters identified.

The arrangements for storage in the building required review. There was a large former church being used for storage purposes. This was a largely undivided and there were excessive combustible materials such as paint and disused furniture and an oxygen cylinder stored within. This could contribute to rapid growth of a fire should one start. To this end, the Provider representative was responsive and by day two of the inspection, had ordered a shed so as to remove excessive combustible material from the church space. The space beneath the main central stairway was used for the storage of combustible materials such as paper and hair drying equipment. This area was not adequately separated from the stairway enclosure in fire rated construction.

Inspectors found that improvements were required in terms of providing adequate containment of fire. The building was subdivided with construction that would resist the passage of fire and smoke in most cases; however, some deficiencies were noted in terms of the integrity of the elements of construction providing fire resistance. Breaches in the fire rated enclosure to a room or corridor that requires fire resistance, results in a passage for fire and smoke to compromise escape routes. For example, the church was not adequately separated from the remainder of the nursing home with fire rated construction. There was an opening at the upper level which was not completed with fire rated construction. This was previously identified by a fire safety consultant. This report was dated 2011.

Three bedrooms were found to have a glazed panel above the fire door, which was not fire-rated. The Provider representative subsequently submitted confirmation to HIOA that these items had been rectified. There was a visible gap between a cross corridor partition and the ceiling above. This would not provide adequate containment during an evacuation, where residents would be horizontally moved through the partition. The adequacy of construction forming lines of fire rated compartmentation for horizontal evacuation required review in some cases.

Inspectors found that fire rated doors were provided throughout the centre, however they were found to have significant deficiencies and required review to ensure their capability to contain a fire and to provide an adequate means of escape for residents. These included doors with large gaps, non-functioning/absent self-closing devices, damaged/ill-fitting door leafs and missing or damaged heat and cold smoke seals. There was a mix of modern and period doors throughout the centre. It was explained to inspectors that the period doors in the building had been upgraded, where required, with specialist paint a number of years ago. Fire doors to some of the day spaces were

not provided with self-closing devices. The Provider representative confirmed that all doors were routinely closed at 11pm. A number of rooms at basement level were not fitted with fire rated doors. The fire door to a room at basement level containing electrical panels was found to be open. The Provider representative was proactive in this regard, and during the inspection had made arrangements for a specialist fire door auditor to come on site within a week to review all fire doors in the centre and to give recommendations to ensure they would perform as required.

The action with regard to drill practices had been partially addressed. At the previous inspection, inspectors found that drill practices required improvement, particularly from the top floor of the main house. The Provider representative had been proactive in this regard by implementing a programme of drills, which were being conducted on a regular basis, simulating night time scenarios where staffing levels are lowest. The records demonstrated that simulated evacuations were timely, the latest of which showed evacuation from the top floor of the main house in two minutes and fifty seconds. However, one bedroom at ground floor level had not formed part of a drill. This room had residents with limited mobility. When spoken with, the Provider representative and Person in Charge were confident in the method of evacuating this area and were consistent in how they described the evacuation procedure to inspectors. The Provider representative confirmed to inspectors they would carry out a simulated drill of this area.

Inspectors found that the needs of residents in the event of a fire were assessed. The documentation was not dated, so it was not clear if the documentation was up to date. This included details on the resident's likely location during the day and at night and also level of mobility, preferred escape route and needs for evacuation.

There were fire procedures adequately displayed throughout the centre. There were drawings displayed also, but they did not accurately identify the extent, size and locations of compartments necessary for evacuation.

The building was laid out in a manner that provided residents and other occupants with an adequate number of escape routes and exits. Exits were secured with electronic locks and opened by way of finger print detection. Activation of the fire detection and alarm system, released these electronic locks. Escape routes were found to be clear and well maintained. The fire procedure for the building accounted for each zone in the building and outlined preferred evacuation routes from each area. The evacuation procedure adopted progressive horizontal evacuation in most areas. Staff spoken to, were found to have consistent responses and knowledgeable with regard to the procedure to be followed in the event of a fire.

The building was provided with a fire detection and alarm system, fire fighting equipment and emergency lighting. The fire detection and alarm system had recently been upgraded to a type L1 system with a repeater panel located in the stairway near the church. Some emergency exit signs were found to be not lit along dedicated escape routes. This was brought to the attention of the Provider representative.

Inspectors saw records of testing of portions of the electrical installation for the centre. However it was not clear from the documentation which areas had been tested. The

Provider explained that the electrics were being reviewed and upgraded as necessary on a phased basis. Considering the age of the building, it would be advisable to have the remainder of the electrical installation reviewed. Where new work was being carried out, such as installation of new sockets, appropriate documentation was obtained from an electrician, which is indicative of good practice.

There was a policy on smoking for the centre. Residents who smoke do so in the designated smoking room. This room was provided with both openable windows and mechanical extract to prevent malodour into other parts of the building. There was a fire blanket in place and extinguishers in close proximity on the adjoining corridor. A vision panel was provided in the door. Residents who smoke are assessed and control measures are identified. Inspectors found the assessment of one resident required further review. The smoking policy indicates smoking aprons are provided for residents at risk of dropping a cigarette. Smoking aprons were not provided in the smoking room.

The Provider representative had made arrangements for appropriate fire safety training to be provided to staff on an annual basis.

When spoken to regarding evacuation procedures, the Provider and person in charge were found to be knowledgeable around fire safety and the procedure for the evacuation of residents. Evacuation procedures were well thought out with centre specific systems in place. For example, where evacuation sheets were required for a resident, this was identified with a clear sign above the bed.

Inspectors looked at the kitchen and laundry facilities in the centre. The Inspectors spoke to a kitchen staff member and found them to be knowledgeable about what to do in the event of a fire and they were able to identify the gas shut off valve to the inspector. There was a commercial scale dryer located in the laundry room. The lint screen was torn and had been replaced with a netted fabric, which did not adequately collect the lint, presenting as a risk to fire. This was a leased machine. The Provider representative contacted the company immediately to resolve the issue.

Inspectors reviewed documentation for in house fire safety checks in the centre. There were daily and weekly checks, such as fire exits, finger print locking releases and door alarms. However, improvement was required in this regard. Inspectors did not see a record of the weekly testing of the fire detection and alarm system and daily checks of the fire alarm panel. The weekly checks for the emergency lighting system were not recorded.

The provider was complying with Condition 8 of the current registration of this centre. From a review of the manual handling assessments of residents accommodated on the top floor, inspectors found that all residents accommodated were independently mobile or required the assistance of one member of staff to mobilise. These residents were assessing other parts of the building by the use of two stair lifts.

Aspects of infection prevention and control required improvement. A cleaners room with a sink and wash hand basin was available. Colour coded brushes were available for different areas. Deficits in aspects of infection prevention and practice, for example inadequate systems for routine deep cleaning of wheelchairs and commodes. Clinical

waste was not secure and procedures were not in place with regard to monitoring of legionella.

Inspectors found that wardrobes had been secured to the walls in bedrooms to ensure they would not topple over.

A risk management policy was in place which complies with the regulations. It detailed measures to control hazards including abuse, unexplained absence of a resident, injury, aggression and self harm. While a risk register was in place this failed to detail some risks in the centre as documented under Outcome 2. Missing persons profiles were in place for all residents.

An emergency plan that took into account a variety of emergency situations was in place. Clinical risk assessments were undertaken, including falls risk assessment, nutritional care assessments.

Neurological observations were completed post un-witnessed falls to monitor neurological function. This was an action from the last inspection.

Risk assessments had been completed for all residents who smoked, however no smoking apron was available in the smoking room even though the smoking policy stated that a smoking apron would be available in the smoking room.

Records were maintained of accidents and incidents. Factual details of the accident/incident, date event occurred, name and details of any witnesses and whether the general practitioner (GP) and next of kin had been contacted.

There were moving and handling assessments available for all residents. All staff had up to date training in manual handling.

Judgment:

Non Compliant - Major

Outcome 09: Medication Management

Each resident is protected by the designated centre's policies and procedures for medication management.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

A policy on medication management was available. This outcome was found to be compliant at the time of the January 2017 inspection. Some aspects of medication management were inspected at the time of this inspection.

Medications for residents were supplied in blister packs from the pharmacy. Medications

were stored in a locked medication trolley which was stored in the clinical room. The temperature of the medication fridge was monitored and recorded daily and medications requiring refrigeration were stored appropriately. Handling and storage of controlled drugs was safe and monitored twice daily by two nursing staff and a register was maintained. Nurses had completed medication management training.

Inspectors reviewed a sample of medication prescription sheets. All medication was signed for by a medical practitioner. Maximum daily doses were specified for 'pro re nata' (PRN) medication. The medication administration record sheets (MARS) identified the medications on the prescription sheet, contained the signature of the nurse administering the medication. Space to record comments on withholding or refusing medications was available. The times of administration matched the prescription sheet

Judgment:

Compliant

Outcome 10: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors noted that a record of all incidents was maintained. Notifications to HIQA were made in line with the requirements of the Regulations.

Judgment:

Compliant

Outcome 11: Health and Social Care Needs

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

Theme:

Effective care and support

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

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

Findings:

The action with regard to personal calendars and consultation with residents with regard

to their care plans was completed.

A physiotherapist visited the centre weekly. Allied health/specialist services such as dental, mental health, dietetics and chiropody was available. Some residents were accommodated in specialist chairs, one was buxton style chair. Two of these residents did not look like they were supported and comfortable in these chairs. Inspectors requested the seating assessments from the person in charge for these two residents. The person in charge stated that she had referred these two residents to an occupational therapist by phone but had not recorded these referrals in the care notes.

A resident was on a specialist modified diet but there was no documented assessment in place by speech and language therapy services to support this and ensure she was obtaining a diet that was suitable to her needs to ensure her safety. The person in charge could not provide clarity as to when the resident was seen by speech and language services and what was their specialist recommendation.

Inspectors requested that the person in charge submit the occupational therapy assessments and speech and language therapy assessment once available. These must be redacted of personal information to protect the confidentiality, privacy and dignity of the residents.

Inspectors reviewed the continence assessments of some residents on admission. These did not provide a good history as to whether the residents' independence could be maintained and enhanced by promoting continence.

Nutritional care plans were in place. Most residents were weighed monthly however the centre did not have a suitable apparatus to weight residents who were unable to use the chair scales. Consequently an up to date weight was not available for all residents.

There was evidence that residents had access to the services of a general practitioner (GP) services. A number of general practitioners were currently providing a service to the centre. An "out of hours" GP service was available if required.

Inspectors reviewed a selection of care plans. A pre-assessment was undertaken prior to admission. On admission, an assessment of resident's needs was completed to include activities of daily living, including risk of falls, nutritional care, manual handling and personal care.

Overall, inspectors found that some care plans were person centred with residents likes and dislikes recorded however where a resident was seen by a specialist service the advice of the specialist was not incorporated into the care plan for example if the resident was seen by psychiatry or later life staff any advice or recommendation that may have made was not incorporated into the care plan to enhance the delivery of person centred care to the resident.

Care plans were reviewed no less frequently than at four-monthly intervals, in consultation with residents and/or their representatives. This was confirmed from reviewing the care plans chatting with residents and from the questionnaires received pre and posts the inspection. This was an action post the January 2017 inspection.

There was evidence of transfer of information between acute services and the centre .

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents, conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The premises were reviewed in detail on the 24 May 2017 inspection.

Changes since the 24th May 2017 inspection included reconfiguration of Room 7 which is a triple room on the top floor. This reconfiguration has provided extra space for residents. Privacy screening was available around each bed in this room and a wardrobe chair and locker was available for each resident. Two conditions are attached to the current registration of this centre. Condition 8 states that residents' who have been assessed as requiring the assistance of more than one member of staff to mobilise may not be accommodated on the second floor as per the plan of the centre made available to the inspectors. Inspectors found that this condition was being implemented. This condition requires to remain on the renewal of registration as no changes have been made for the transfer of residents between the ground, first and second floors of the building. Chair lifts are the only method of transfer between floors.

Condition 9 related to the reconfiguration of the centre with a timescale attached on July 2015. The provider applied for an application to vary this timescale. Condition now states

'The physical environment in the designated centre must be reconfigured as outlined in the plans submitted to the Chief Inspector on 27 March 2017. The reconfiguration must be complete by 30 April 2019. This condition is attached to ensure that all existing and future residents are afforded appropriate dignity and privacy through the provision of adequate personal space and ensure that the premises meets the needs of these residents.

Inspectors reviewed Room 1 which is a four bedded room. The findings on this inspection regarding the use of room one are based on the dependency of residents and evidence seen on the days of inspection. This room is not suitable to accommodate four

high dependency residents due to its location and proximity to toilets /showers/bathroom and ensure their privacy and dignity is protected.

Inspectors spoke with the provider representative with regard to reconfiguring room one and she gave a verbal commitment that the occupancy of this room would be two high dependency residents and two residents who were weight bearing or required the assistance of one person for mobilising. This would be based on completion of a mobility assessment. The provider agreed to submit a drawing of the reconfiguration of both rooms seven and one.

Inspectors noted that there was some recent signage erected naming the corridors. However there could be greater utilisation of colour and aids such as dementia friendly clocks, especially on room doors to assist residents to orientate themselves in the centre.

No risk assessment was in place with regard to the ramp at the rear of the dining room on the first floor.

Judgment:

Non Compliant - Moderate

Outcome 13: Complaints procedures

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

The person in charge was nominated with overall responsibility to investigate complaints. The provider representative was named in the policy to provide oversight of the complaints procedure and ensure records were maintained. A summary of the complaints procedure was displayed in the centre and was included in the statement of purpose.

A complaints log was in place. There was confirmation that the complaints initiator was satisfied with the outcome of the complaint. The contact details of the office of the Ombudsman were recorded in the policy.

Judgment:

Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her

physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was no resident actively receiving end of life care at the time of this inspection. Staff described how they would ensure that residents' physical, emotional, social, psychological and spiritual needs would be met. Residents approaching end of life had end of life care plans in place. Where residents had expressed specific wishes these were documented. Resident's choice regarding transfer to hospital was recorded.

Judgment:

Compliant

Outcome 15: Food and Nutrition

Each resident is provided with food and drink at times and in quantities adequate for his/her needs. Food is properly prepared, cooked and served, and is wholesome and nutritious. Assistance is offered to residents in a discrete and sensitive manner.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

One of the inspectors visited the kitchen and spoke with the chef on duty. The inspector found that there was a good supply of foodstuffs in stock. Residents were screened for nutritional risk on admission.

As discussed under Outcome 2 the list of current requirements and interventions, such as, modified consistency diets, updated recommendations of the speech and language therapist and whether the resident was on a fortified diet or what type of supplements had been prescribed was not up to date in the kitchen, it was dated 2014.

One of the inspectors observed some residents having their mid-day meal in the dining room. There were two sittings for the mid-day meal at 12:15 and 13:00hrs. Adequate staff were available to assist residents. Residents confirmed to the inspector that they were happy with the food served.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation
Residents are consulted with and participate in the organisation of the centre. Each resident's privacy and dignity is respected, including receiving visitors in private. He/she is facilitated to communicate and enabled to exercise choice and control over his/her life and to maximise his/her independence. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Issues with regard to respecting residents' privacy and dignity and the use of multi occupancy rooms are discussed in detail in the report of the 24 May 2017 inspection. Residents consultation and access to meaningful activities is detailed in the report of the 24/25 January 2017.

Inspectors noted in case files reviewed that communication assessments and care plans were not in place for residents who had cognitive impairment or dementia.

An activity co-ordinator was in place 20 hrs per week. She informed the inspectors she generally worked 4 days per week, five hours each day. She described a range of activities that formed part of the meaningful activity programme. Residents were seen to enjoy a pampering session on day one of the inspection.

There are three sitting rooms in the centre. One of the inspectors observed that while activities were going on in the main sitting room there were five residents who were observed in the small sitting room sat for long periods without any stimulation or activities to meet their needs. On occasions staff popped in to check on residents but there was no staff available for some periods of up to 15 minutes. These residents were immobile and unable to leave their chairs without staff assistance and would have been unable to summon assistance due to their cognitive impairment and immobile.

The centre operated a flexible visiting policy. Mass was celebrated weekly and the rosary and prayers are a daily part of the activity programme.

The last residents' meeting took place on the 18 August 2017. 18 residents attended. Prior to this a meeting occurred on the 10 May 2017. Items discussed include and day to day running of the centre and naming of the corridors. An advocacy service is available to residents

Judgment:

Non Compliant - Moderate

Outcome 17: Residents' clothing and personal property and possessions
Adequate space is provided for residents' personal possessions. Residents can

appropriately use and store their own clothes. There are arrangements in place for regular laundering of linen and clothing, and the safe return of clothes to residents.

Theme:

Person-centred care and support

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

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

Findings:

There was a policy in place for the management of resident's possessions. Sufficient storage space was available in residents' bedrooms which included a wardrobe and a bedside locker. However some wardrobes were not located in close proximity to the beds. This is discussed in the report of this centre completed in May 2017.

There were arrangements in place for regular laundering of linen and clothing and the safe return of clothes to residents.

Judgment:

Substantially Compliant

Outcome 18: Suitable Staffing

There are appropriate staff numbers and skill mix to meet the assessed needs of residents, and to the size and layout of the designated centre. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice. The documents listed in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 are held in respect of each staff member.

Theme:

Workforce

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

No actions were required from the previous inspection.

Findings:

The staff roster accurately reflected the numbers of staff on duty. Inspectors reviewed the actual and planned staff roster and the staff numbers on the day correlated with the roster. Residents and staff spoken with expressed no concerns with regard to staffing levels. Staff were available to assist residents however residents in the small sitting room on the first floor were not supervised at all times.

Residents were complimentary of the staff and described them as kind and caring. A registered nurse was on duty at all times.

The normal allocation of staff on duty was the person in charge, one nurse and three care assistants up to 16:00 hrs, and one nurse and three care assistants up to 20:00hrs

and one nurse and two care assistants on night duty. The provider representative stated that she would instruct that night staff were to document increased surveillance in this area at the back as this was an area that required review with regard to fire safety.

An activity therapist works 20 hours per week. Additional catering, housekeeping, maintenance and administration staff is available. A staff training programme was on-going. All staff had up to date training in fire safety, adult protection and manual handling. Additional training for example infection prevention and control, hand hygiene, medication communication, continence assessment and management was required. An Bord Altranais agus Cnáimhseachais na hÉireann registration numbers were available for all registered nursing staff employed.

Staff are kept informed on changes to residents' health status through handover meetings, care plans and daily diaries. Staff meetings took place. Topics discussed include policies and day to day running of the centre.

Judgment:

Compliant

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Mary McCann
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 report¹

Centre name:	Ballinamore House Nursing Home
Centre ID:	OSV-0000317
Date of inspection:	20/09/2017
Date of response:	01/12/2017

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: Statement of Purpose

Theme:

Governance, Leadership and Management

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

Inspectors reviewed the statement of purpose and noted it required review to ensure it describes the services provided in detail and how it is to be provided to include the layout of the premises where residents are accommodated and facilities that are provided.

1. Action Required:

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

Under Regulation 03(1) you are required to: Prepare a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

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

We have reviewed our Statement of Purpose and although it contains all the information outlined in schedule 1 and in the guidance provided by HIQA, we will add the further information requested by the inspectors.

As requested, we hereby submit our updated Statement of Purpose to enable HIQA to assist the Chief Inspector to progress re-registration of our centre in accordance with Section 50 of the Health Act 2007.

Proposed Timescale: 01/12/2017

Outcome 02: Governance and Management

Theme:

Governance, Leadership and Management

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

The annual review of the quality and safety of care delivered to residents required further input to ensure that it was used as way of seeking to improve the quality and safety of care provided. No quality improvement plan had been developed post completion of this report.

Environmental and clinical risks were identified by the inspectors that had not been identified in audits completed by the provider representative/person in charge. These related to potential risks to residents including fire safety, the ramp at the rear of the dining room, waste management not appropriately managed, as the clinical waste was not secured and domestic waste bins were overflowing. A robust decontamination programme for equipment used by residents was not in place and a monitoring system for water testing and vents to minimise the potential spread of healthcare associated infections.

No signs were in place indicating that oxygen was stored.

No risk assessment was made available to inspectors with regard to the safe storage of gloves and aprons.

The list for informing catering staff as to the type of special diet a resident was to receive was not up to date this posed a risk to residents of getting the wrong consistency of food according to their assessed needs.

Minutes of weekly meetings were available between the provider and person in charge. However no agenda was available for these meetings and no action plan was developed for any issues identified.

2. Action Required:

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

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

We will review our annual review from 2016, and commence work on this year's review
Oxygen cylinders have been relocated.

Risk assessment for safe storage of gloves and aprons, hand rail at dining room will be completed.

The lock on the clinical waste bin was broken; the bin has been replaced by the contractor who provides the clinical waste bin.

At the time of inspection on there was 5 domestic waste bins in site, 1 bin was full and lid was not closed fully on it. We have discussed with our bin suppliers and they have replaced our bin for a larger capacity bin.

We have a robust intensive cleaning system in place which covers the decontamination of equipment, but we will review this again.

We have a system in place for testing water.

List for special diets has been updated.

We use a template document for our weekly meeting which we feel meets our needs, this document covers 11 points to be discussed which includes, unresolved issues from previous meeting, corrective actions, Accidents/incidents/near misses, medication errors, complaints or concerns, feedback from residents meetings, welfare/health and safety including maintenance and infection control, clinical governance and end of life care, external reports, staff – recruitment and training and any other matters. Anything that is highlighted under any of these topics there is a timeframe set and person responsible for same is identified. Anything that arises outside of these headings can be highlighted under 'any other businesses.

To enable HIQA to assist the Chief Inspector to progress the re-registration of our centre pursuant to Section 50 of the Health Act 2007, we attach:

- Risk assess for handrail;
- Revised intensive cleaning schedule;
- Relevant part of our infection control policy which identifies equipment/cleaning approach;
- Up-to-date water test results and we confirm that water is tested every three months by an external company. We confirm that this company takes a sample from different areas of the centre on each testing occasion so that within the calendar year, water samples are taken and tested within every area of the centre; and
- Template of weekly management meetings minute; and
- Most recent quality improvement plan.

Proposed Timescale: 31/12/2017

Outcome 03: Information for residents

Theme:

Governance, Leadership and Management

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

A residents' guide was made available to the inspectors at the time of inspection. On review this was found to contain all of the information required by the Regulations however it was not accessible to residents with dementia or cognitive impairment. An accessible version was required.

3. Action Required:

Under Regulation 20(1) you are required to: Prepare and make available to residents a guide in respect of the designated centre.

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

We welcome the suggestion of having an accessible version of the residents guide.

Proposed Timescale: 30/12/2017

Outcome 05: Documentation to be kept at a designated centre

Theme:

Governance, Leadership and Management

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

Approved operational policies were not implemented in practice to ensure resident and staff health and safety, identify and manage risks for example with regard to fire safety, food and nutrition and infection control.

4. 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 are currently undertaking a review of our policies, auditing and risk management practices within the centre.

Proposed Timescale: 30/12/2017

Theme:

Governance, Leadership and Management

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

Certificates for the emergency lighting system were not available.

Some records were incomplete for example cleaning rosters for toilets. Some records were not up to date for example, the list of specialist diets and feeding guidelines for residents.

Communication and continence assessments required reviewed to ensure they were more comprehensive and they enhanced the independence of residents.

5. Action Required:

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

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

Certificates for emergency lighting have been submitted to HIQA

Special diet list has been updated.

Staff meeting held to remind staff the importance of signing the cleaning roster for toilets.

Continence assessments are completed in order to receive the incontinence wear from the HSE; an updated assessment will be kept in the residents care plans.

Communication care plans will be reviewed.

Proposed Timescale: 30/11/2017

Outcome 08: Health and Safety and Risk Management

Theme:

Safe care and support

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

No risk assessment was made available to inspectors with regard to the safe storage of gloves and aprons. Where residents who are cognitively impaired or have dementia they may be at risk of ingesting gloves and choking was referenced under outcome 2.

6. Action Required:

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

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

Risk assessment for storage of gloves and aprons has been completed-copy attached.

Proposed Timescale: 30/12/2017

Theme:

Safe care and support

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

Deficits in aspects of infection prevention and practice, for example inadequate systems for routine deep cleaning of wheelchairs and commodes. Clinical waste was not secure and procedures were not in place with regard to monitoring of legionella.

7. Action Required:

Under Regulation 27 you are required to: Ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.

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

Our deep cleaning system will be revised.
Clinical waste bin has been replaced
We will have a system in place to monitor for legionella.

Proposed Timescale: 30/11/2017

Theme:

Safe care and support

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

Improvements were required in terms of providing adequate containment of fire as detailed in the body of the report.

The provision of fire resistant doors required assessment to ensure that fire resistant doors are provided where required.

Fire resistant doors required review to ensure their capability to contain a fire and to provide an adequate means of escape for residents. These included doors with large gaps, non-functioning/absent self-closing devices, damaged/ill-fitting door leafs and missing or damaged heat and cold smoke seals.

8. Action Required:

Under Regulation 28(2)(i) you are required to: Make adequate arrangements for detecting, containing and extinguishing fires.

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

Since the inspection we have had 3 visits by a specialised fire door company who have assessed all our fire doors and have prepared a report and have given advice which we are acting upon prioritising the work that has to be completed. New doors have been measured and ordered.

Information to HIQA on the 29/09/17 confirming that the glazing over fire doors and provision of fire rated construction separating the church, gap between fire rated partition and ceiling was completed. The glazing over 5 doors was removed and replaced with double slabbing both sides with half inch fire proof fire board and plastered. The existing timber structure was removed a steel stud was put in place, a double slabbed fire proof plaster board was fitted both sides.

New fire doors have been ordered and will be fitted upon their arrival.

Proposed Timescale: 01/12/2017

Theme:

Safe care and support

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

The drawings displayed did not identify the extent, size and location of fire compartments necessary for phased evacuation

A number of emergency exit signs were observed where the lighting unit was not permanently lit.

9. Action Required:

Under Regulation 28(3) you are required to: Display the procedures to be followed in the event of fire in a prominent place in the designated centre.

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

The drawings are been reprinted to highlight the information identified.
The emergency exit units are permanently lit now.

Proposed Timescale: 30/11/2017

Theme:

Safe care and support

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

Storage arrangements in the building required review.

An oxygen cylinder was not appropriately stored.

The lint screen in the large dryer was damaged and replaced with netted fabric, which did not adequately collect lint.

10. Action Required:

Under Regulation 28(1)(a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.

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

We have reviewed storage in the building
Oxygen cylinder has been relocated to the clinical room.
The lint screen was replaced on the 29th of September 2017.

STORAGE

We have had 3 skips since the inspection and disposed of any unnecessary items. Going forward in our plans for renovation the church area will be a designated usable area and not a storage area.

Paper items from under the stairs have been removed to the office area.

As stated above the oxygen cylinder has been removed. It was removed from the church area which was highlighted as been problematic; it was moved to the treatment room where it can be accessed in emergency cases. We have a risk assessment in place for the storage of oxygen cylinder (attached).

Proposed Timescale: 31/10/2017

Theme:

Safe care and support

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

The system of in house fire safety checks required review to ensure they were of adequate extent, frequency and detail.

11. Action Required:

Under Regulation 28(1)(c)(i) you are required to: Make adequate arrangements for maintaining all fire equipment, means of escape, building fabric and building services.

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

The fire safety checks have been reviewed

Since the inspection we have added checking of the fire panel to our daily checklist (copy of which is attached). We have a system in place for checking extinguishers, fire exits, emergency lighting, doors (copy attached). Along with carrying out monthly fire drills we also do weekly sounding of the alarm (copy attached). Our maintenance person has attended a conference regarding Fire Safety in Multi-storey buildings, Apartments & Flat Complexes on the 22nd November 2017 (copy of certificate of Attendance attached).

Proposed Timescale: 30/11/2017

Outcome 11: Health and Social Care Needs

Theme:

Effective care and support

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

Inspectors reviewed the continence assessments of some residents on admission. These did not provide a comprehensive history as to whether the residents' independence could be maintained and enhanced by promoting continence.

The centre did not have a suitable apparatus to weight residents who could not sit in a chair or stand on weighing scales.

12. Action Required:

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

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

Continence assessments will be completed. However we do address resident's continence and needs within individual continence care plans which are regularly reviewed.

Marsden hoist weighing attachment has been purchased and received for residents who are unable to use chair scales

Proposed Timescale: 30th November 2017 for continence assessments
12th October 2017 for hoist attachment

Proposed Timescale: 30/11/2017

Theme:

Effective care and support

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

Seating assessments were not available for some residents accommodated in specialist chairs.

A resident was on a specialist modified diet but there was no assessment documented in her clinical records to support this and ensure she was obtaining a diet that was suitable to her needs

The list for informing catering staff as to the type of special diet a resident was to receive was not up to date.

13. Action Required:

Under Regulation 06(2)(c) you are required to: Provide access to treatment for a resident where the care referred to in Regulation 6(1) or other health care service requires additional professional expertise.

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

OT seating assessments have been completed and reports are available, chairs have been ordered with an approximate 3 week wait for company that are making them. Speech and Language assessments and recommendations are available for any resident who has a specific requirement. In relation to the resident with no clear guidelines documented this resident was transferred from an acute setting without any guidelines, we as nurses used our clinical knowledge and assessment skills to put in place a temporary plan for the resident until they could be assessed by a speech and language therapist, this assessment occurred on the 23rd of September who concurred that the steps we had in place were adequate and appropriate for the residents needs.

The list for catering staff has been updated.

We have attached OT assessments for resident A and B. Speech and language assessment attached

Proposed Timescale: 4th of December 2017 (estimated time for chairs as they have to

be manufactured and delivered)

Proposed Timescale: 04/12/2017

Outcome 12: Safe and Suitable Premises

Theme:

Effective care and support

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

The provider representative agreed to reconfigure room 1 and submit a drawing of the reconfiguration of both rooms seven and one.

Inspectors noted that there was some recent signage erected naming the corridors. However there could be greater utilisation of colour and aids such as dementia friendly clocks, especially on room doors to assist residents to orientate themselves in the centre.

No risk assessment was in place with regard to the ramp at the rear of the dining room on the first floor.

14. 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:

Bedroom 1 reconfiguration and drawing currently been addressed.

The signage erected naming the corridors were chosen by our residents. We intend to utilise colour in our corridor areas, we have dementia friendly clocks, however we have been advised by the fire door expert that adding any signage or colouring to bedroom doors interferes with their fire safety rating.

A risk assessment in relation to the ramp at the back of the dining room will be completed.

We have attached the reconfiguration drawings of room 1 and room 7.

Proposed Timescale: 30/01/2018

Outcome 16: 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:

One of the inspectors observed that while activities were going on in the main sitting room there were five residents who were observed in the small sitting room sat for long periods without any stimulation or activities to meet their needs. On occasions staff popped in to check on residents but there was no staff available for some periods of up to 15 minutes. These residents were immobile and unable to leave their chairs without staff assistance and would have been unable to summon assistance due to their cognitive impairment and immobile.

15. 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:

Our activities co-ordinator discussed at length with the inspector that the residents in that particular dayroom attended appropriate activities in the other day room throughout the day. She also explained to the inspector that she attended all day rooms for activities including the small day room. This day room is situated right beside the nurse's station and throughway for staff and is monitored on a regular basis. We will look at the activity level in this area.

Proposed Timescale: 30/11/2017

Theme:

Person-centred care and support

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

Inspectors noted in case files reviewed that communication assessments and care plans were not in place for residents who had cognitive impairment or dementia.

16. Action Required:

Under Regulation 10(2) you are required to: Where a resident has specialist communication requirements record such requirements in the resident's care plan prepared under Regulation 5.

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

Care plans will be reviewed to reflect needs of residents with cognitive impairment of dementia

Proposed Timescale: 30/11/2017

Outcome 17: Residents' clothing and personal property and possessions

Theme:

Person-centred care and support

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

There was a policy in place for the management of resident's possessions. Sufficient storage space was available in residents' bedrooms which included a wardrobe and a bedside locker. However some wardrobes were not located in close proximity to the beds.

17. Action Required:

Under Regulation 12 you are required to: Ensure that each resident has access to and retains control over his or her personal property, possessions and finances.

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

Due to the configuration of bedrooms wardrobes are located as close as possible to residents beds this will be addressed with the extension

Proposed Timescale: 29/04/2019