# Health Information and Quality Authority Regulation Directorate

## Compliance Monitoring Inspection report

Designated Centres under Health Act 2007, as amended

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>Mac Bride Community Nursing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0000647</td>
</tr>
<tr>
<td>Centre address:</td>
<td>St. Mary's Crescent, Westport, Mayo.</td>
</tr>
<tr>
<td>Telephone number:</td>
<td>098 255 92</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:julie.silke@hse.ie">julie.silke@hse.ie</a></td>
</tr>
<tr>
<td>Type of centre:</td>
<td>The Health Service Executive</td>
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<tr>
<td>Registered provider:</td>
<td>Health Service Executive</td>
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<tr>
<td>Provider Nominee:</td>
<td>Julie Silke-Daly</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Mary McCann</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td>None</td>
</tr>
<tr>
<td>Type of inspection:</td>
<td>Unannounced Dementia Care Thematic Inspections</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>26</td>
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<tr>
<td>Number of vacancies on the date of inspection:</td>
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About Dementia Care Thematic Inspections

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

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

Please note the definition of the following term used in reports: responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
Compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

<table>
<thead>
<tr>
<th>From</th>
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<tr>
<td>04 May 2017 15:00</td>
<td>04 May 2017 20:00</td>
</tr>
<tr>
<td>05 May 2017 09:00</td>
<td>05 May 2017 15:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Provider’s self assessment</th>
<th>Our Judgment</th>
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<tbody>
<tr>
<td>Outcome 01: Health and Social Care Needs</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 02: Safeguarding and Safety</td>
<td>Compliance demonstrated</td>
<td>Non Compliant - Moderate</td>
</tr>
<tr>
<td>Outcome 03: Residents' Rights, Dignity and Consultation</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 04: Complaints procedures</td>
<td>Compliance demonstrated</td>
<td>Substantially Compliant</td>
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<tr>
<td>Outcome 05: Suitable Staffing</td>
<td>Compliance demonstrated</td>
<td>Substantially 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>Compliance demonstrated</td>
<td>Substantially Compliant</td>
</tr>
<tr>
<td>Outcome 12: Notification of Incidents</td>
<td>Compliance demonstrated</td>
<td>Compliant</td>
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Summary of findings from this inspection

This inspection report sets out the findings of a two day dementia thematic inspection which focused on the care and quality of life for residents with dementia living in the centre. The inspector focused on six outcomes that had direct impact on dementia care and followed up on the seven actions from the previous inspection, four actions had been completed. Two were partially complete, these related to submission of notifications and completion and recording of fire drills. One was not addressed – this related to inadequate space in the dining room for residents. This is discussed further under outcome 12 premises.
The centre does not have a dementia specific unit. At the time of this inspection, of the 26 residents accommodated, ten had a formal diagnosis of dementia and nursing staff stated that approximately a further four had a cognitive impairment. The inspector tracked the journey of four residents with dementia within the service. The inspector used an observational tool (QUIS) in which social interactions between residents and care staff are observed and coded as positive social, positive connective care, task orientated care, neutral, protective and controlling or institutional care/controlling care was used by the inspector. The results reflect the effect of the interactions on the majority of residents. (This is discussed further under Outcome 16).

A mental state assessment is completed on all residents on admission. This looks at memory or other mental abilities and helps to diagnose dementia and assess its progression and severity. It also is used to assess changes in a person who has already been diagnosed with dementia and can help to give an indication of how severe a person's symptoms are and how quickly their dementia is progressing.

As part of the preparation for this inspection the provider was requested by the Health Information and Quality Authority (HIQA) to submit a provider self assessment tool on dementia care and submit policies on responsive behaviour, admission procedures, communication and restraint management. These were received and reviewed prior to the inspection. With regard to the self assessment the provider had rated the centre to be compliant with outcomes on health and social care needs, safeguarding and safety, residents’ rights, dignity and consultation, complaints procedure and management, suitable staffing and substantially complaint with regard to safe and suitable premises.

The inspector found that the centre met the individual care needs of residents with dementia. Residents were well known by staff and the care needs of residents with dementia were met. There was a relaxed atmosphere in the centre and residents told the inspector they were happy living in the centre. At the feedback meeting at the end of the inspection, the findings were discussed with the person in charge. Areas requiring improvement post this inspection in order to comply 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 including safe moving and handling training for staff, review of the dining room, regular completion of fire drills and review of the policy and procedure with regard to complaints.
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 relates to assessments and care planning, access to healthcare, nutritional care, medication management and end of life care.
This outcome was judged to be compliant in the self-assessment, the inspector judged it as substantially compliant. The area of non compliance was due to the fact that there was poor evidence available that the care plans were made available to the resident and with their consent the relative. However residents told the inspector that they were consulted with regard to their care and their viewed were sought.

Pre admission assessments were generally conducted by the person in charge which considered the health and social needs of the potential resident and any preparatory work that was required prior to their admission to the centre.
Residents' confirmed to the inspector that they were well cared for, the food was good and staff were attentative to their needs. From talking with staff and residents the inspector found that staff provided care in a person centred way and tried to assist the resident to maintain their independence. Risk assessments and care plans were reviewed on a four monthly basis or in response to the changing needs of residents.

The provider facilitated weekly physiotherapy input to support residents’ independence with their mobility needs, assess residents and implement treatment plans and review residents if at risk of falls or posts a fall.

The inspector reviewed policy and practice around systems to ensure that the nutritional needs of all residents were well met. All residents were appropriately assessed for nutritional needs on admission and were reviewed regularly. The care plans of those residents with dementia which were reviewed contained relevant assessments including risk in relation to safe swallowing and adequate nutritional intake. Most staff had received training in dysphagia and a good communication existed to ensure that all staff to include care, nursing and catering had up to date knowledge of the residents
needs. The inspector spoke with the chef and catering assistant who displayed a good knowledge of the current requirements of residents.

Likes and dislike were recorded and residents told the inspector that these were respected. The menu was varied and kitchen staff confirmed that fresh meat, vegetables, fish and fruit was available. There were scheduled deliveries of stores and the centre also had an account with a local shop for any top up items required. Scones, brown bread and homemade cakes and deserts were available. As part of a healthy eating plan deserts were not available unless by special request two days per week. Soup was available daily pre dinner.

Residents on a modified diet could choose from the same menu and these meals when served were well presented. Resident weights were recorded on at a monthly basis and more regularly according to clinical need. Throughout the inspection residents were seen to be provided with regular snacks and drinks. Residents who required support at mealtimes were provided with timely assistance from staff. Those with any identified nutritional care needs had a nutritional care plan in place. any residents who was assessed as at a risk of nutritional deficit or had unintentional loss triggered a referral to a dietician.

Residents who required support at mealtimes were provided with timely assistance from staff.

While there were no residents with pressure ulcers on the day of inspection, pressure ulcer prevention and management practice was in place for residents assessed as being at risk with appropriate aids such as specialist mattress or cushions.

A comprehensive policy was in place on the delivery of care at end of life care. Training records supported that a number of staff had undertaken training in end of life care. In the sample of care plans reviewed there was evidence of discussion with residents about their wishes and there was also evidence where appropriate of input from the families and significant others.

There was good evidence that practice and systems to prevent unnecessary hospital admissions were in place such as review by the general practitioner (GP) and the person in charge also confirmed that the centre was well supported by community palliative care services. A relatives room was available, this had an en-suite toilet and a sofa bed. Residents who had been transferred into and out of hospital had copies of their transfer letter from the centre to the acute hospital held on file together with nursing, medical transfer letters and discharge summaries from the acute hospital back to the centre.

Residents had access to medical and allied health care professionals to include chiropody, dental care, speech and language, dietician, and tissue viability. Evidence was seen that a general practitioner (GP) visited the centre to see residents regularly and an out of hours medical care service was also available.

Processes in place for the handling of medicines, including controlled drugs, were safe
and in accordance with current guidelines and legislation, a comprehensive medication policy was available. Medicine prescription and administration records for residents were legible and well maintained. These included a photograph to assist with identity of the resident, weight, date of birth, General Practitioner name and any known allergies.

Judgment:
Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

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

Findings:
At the last Inspection, improvements were required regarding the implementation of safeguarding policy and the timely response to allegations, disclosures or suspected abuse. This had been addressed. The inspector found appropriate and up to date policies in place regarding the prevention, detection and response to abuse. Staff spoken to by the inspector confirmed that they had received training on safeguarding vulnerable adults and were aware of the different forms of abuse and the reporting structure within the designated centre. All staff had been trained in Adult protection and regular refresher training was scheduled.

The person in charge confirmed that they had enacted the new policy on safeguarding in the centre. Residents spoken to stated they felt safe in the designated centre and informed the inspector that they were well cared for. An investigation was on-going with regard to an allegation of abuse. Procedures were in place to protect residents but a documented risk assessment with control measures in place was not in place detailing these procedures. The person in charge demonstrated awareness of the need to continually monitor safeguarding within the designated centre and was the designated officer with regard to safeguarding, she had also completed the train the trainer course in safeguarding vulnerable adults. Plans were in place for all staff to undertake the revised safeguarding training.

The inspector reviewed the use of restraint within the centre. A policy on enabler/restraint use was in place to guide practice in place. There were risk assessments completed for residents who had bed rails in place. There was evidence available that staff were trying to reduce the number of residents who had bedrails and all beds with the exception of three were low low beds. Most bedrails were in use as enablers but care plans in place did not detail the enabling function of the restraint measure. Records indicated that restraint was only used following a risk assessment. There was evidence that restraint measure in place were regularly reviewed by the person in charge.
There was a policy on the management of responsive behaviour. A small number of residents presented with responsive behaviour and records indicated the use of behaviour charts to support the identification of precipitating factors to enable staff to recognise triggers and try and alleviate the underlying cause of the behaviour. However, clear concise behaviour management care plans were not in place to provide direction to staff as to how to manage responsive behaviour and the plans failed to identify what triggers had been identified in the completed ABC (assessment, behaviour and consequences) charts. Residents with responsive behaviour had been seen by specialist services but there was poor evidence of their advice or input in the behaviour support plans.

The inspector reviewed the management of residents’ finances in the centre. Residents were generally responsible for their own finances either independently or with the support of family. The centre acted as an agent of behalf of a minority of residents. There were records in place regarding this procedure. The centre operated a safe keeping system for nominal funds for residents and in these instances, systems were in place to safeguard these with protocols around recording transactions with two signatures by staff. A sample record of these reviewed was in keeping with protocols and the amounts retained reconciled with the figures documented.

The provider had stated in the self assessment that the centre was compliant in this area. The inspector found that this outcome was non compliant - moderate.

**Judgment:**
Non Compliant - Moderate

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**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:**
The inspector was satisfied that residents were consulted on the organisation of the centre. Staff displayed a good knowledge of residents needs and were eager to ensure that residents views were respected and were involved in the running of the centre. The inspector saw that residents had requested that fish be available three times per week on the menu and this was occurring. An independent advocate was available with their contact details on display. Residents meetings occurred three times in 2016. Minutes were available of these meetings, which showed a general discussion of the running on the centre and residents described a good level of satisfaction with the care and service they were receiving. One had been held to date in 2017. Staff described informal individual consultation with residents occurring on a regular basis. However the
inspector noted that a residents’ survey had been completed in 2015 and 2016. Similar issues with regard to for example, residents unaware of menu choices, unsure if they were asked their likes and dislikes was contained in the 2015 and 2016 questionnaires. No quality improvement plan had been enacted post either survey to review issues raised.

An activity schedule was in place and an activity co-ordinator works part-time. An assessment of all residents preferred activities had been completed. This informed the activity schedule. Scheduled activities included aromatherapy, music, dog therapy, reminiscence, hand massage, imagination gym, poetry, proverbs, and reading the local and national newspapers. A staff member had completed Sonas (a therapeutic activity for residents who are cognitively impaired) training and Sonas was a regular activity provided in the centre. Some residents chose to spend time in their bedrooms watching TV or with visitors or friends according to their own individual preferences. Those residents with more cognitive impairment were observed to receive one-on-one attention from staff.

There were no restrictions on visitors attending the centre. An oratory was available and a priest attended the centre on a weekly basis to celebrate Mass. Other pastoral services could also be made available if required. Arrangements were in place to facilitate residents to vote if they wished. The community was actively involved in the centre and various arts sessions were organised for Bealtaine. Residents had access to radio, TV and could use the centre telephone if required.

The inspector observed staff providing assistance to residents where required and noted that the manner and attitude of staff was pleasant with a good rapport between staff and residents.

Most staff had undertaken training in dementia care and management of responsive behavior. There were no restrictions on visitors and residents could meet visitors in private in the relatives’ room. Observations of the quality of interactions between residents and staff in communal areas of the centre for selected periods of time indicated that the majority of interactions between staff and residents were positive. There were a minor number of task orientated activities observed where staff responded to the resident but did not utilise the interaction as positive meaningful engagement. No negative interactions were observed.

The provider had stated in the self assessment that the centre was compliant in this area. The inspector found that this outcome was substantially complaint.

Judgment:
Substantially Compliant

Outcome 04: Complaints procedures

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

Findings:
Policies and procedures were in place for the management of complaints. However, the policy and procedure was confusing as both the provider and person in charge were documented as the complaints officer for the centre. The policy also failed to document details of the ombudsman.

The complaints process was displayed in a prominent place and residents expressed confidence in the process. Residents stated they had no concerns about speaking with staff if they had a concern. The inspector viewed the complaints log. No complaints were recorded for 2016/2017 to date. Three complaints were recorded for 2015. Those recorded were addressed appropriately, but these complaints were recorded in a communal book. Consideration should be given to recording complaints individually. The provider had stated in the self assessment that the centre was compliant in this area. The inspector found that this outcome was substantially complaint.

Judgment:
Substantially Compliant

Outcome 05: Suitable Staffing

Theme:
Workforce

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

Findings:
There was a clear management structure in place and staff were aware of the reporting mechanisms and the line management system. There were 26 residents residing in the centre at the time of inspection with three vacancies. 14 residents who had maximum dependency needs, two high dependency needs, five medium dependency needs and five were assessed as low dependency. The inspector reviewed duties rota\s over a three week period and found they demonstrated that there were sufficient numbers of staff on duty to meet the needs of residents. All residents and staff spoken with expressed no concerns with regard to staffing levels. Staff were available to assist residents and residents were supervised at all times.

An actual and planned roster was maintained in the centre. There were generally three nurses on duty during the day and the person in charge Monday – Friday. Two nurse were generally on duty Saturday and Sunday. There were three health care assistants rostered to care for residents up until 20:00 hrs with two from 20:00 to 21:00 hrs daily.
On night duty there were two staff, one nurse and one care assistant. In addition to the nursing and care staff, a maintenance person, physiotherapist and activity coordinator were employed part-time. Laundry, catering and administrative staff were also available. The inspector noted that the day room was supervised at all times and there was adequate staff on duty to assist residents at meal times. In addition to the nursing and care staff, the centre had employed a maintenance person, physiotherapist and activity coordinator part-time. Laundry catering and administrative staff were also available.

Staff were observed to interact with the residents in a caring, patient and respectful manner. The person in charge confirmed that there was a low turnover of staff. Appropriate recruitment procedures were evident. Personal identification registration numbers were available for all nursing staff with an Bord Altranais agus Cnáimhseachais na hÉireann were available.

The person in charge informed the inspector that staff were supervised according to their role. An induction system was in place for new staff with training in policies and procedures included. A record of the induction was maintained in staff personnel files. Staff had received training to include adult protection, end of life care, responsive behaviour, fire safety, dysphasia and infection control. Staff had also attended specialised academic courses on gerontology and online medication training. Safe moving and handling training had expired for many staff. The person in charge had requested training in this area and future dates were identified for training.

The provider had stated in the self assessment that the centre was compliant in this area. The inspector found that this outcome was substantially complaint.

**Judgment:**
Substantially Compliant

**Outcome 06: Safe and Suitable Premises**

**Theme:**
Effective care and support

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

**Findings:**
At the time of the last inspection the inspector observed that all residents did not have sufficient space to attend the dining room and those that did had limited space. This remained the case. One sitting was scheduled for lunch and one for tea-time. Day care is provided from Tuesday – Thursday with one to five persons attending. Those attending day care share the same communal spaces as residents.
The Mc Bride Community Nursing Unit is a purpose built single-storey Health Service Executive (HSE) care facility built in 1974 situated in Westport town. Two enclosed gardens, one of which is a sensory garden provide safe accessible outdoor areas for residents. It is registered with the Health Information and Quality Authority (HIQA) to provide care to 29 residents, 28 long stay beds and one respite bed. The structural layout of the unit consists of 21 single rooms with a wash-hand basin and four twin rooms with en-suite facilities. Other facilities include a day room, sitting room, visitors/relatives room including accommodation for relatives overnight, oratory, dining room, store room, offices. Seven toilets, three showers and one bathroom are available in addition to the four en-suites. The unit provides nursing care to those whose healthcare needs cannot be met through community services, families or carers. The layout of the centre was in keeping with the statement of purpose and supported the needs of those with a cognitive impairment in facilitating ease of movement from communal areas to the residents’ private space. The entry was accessible by a ramp. Externally the grounds provided a pleasant well maintained. Residents were seen to avail of the outside space mobilising independently.

The centre was recently refurbished and was clean, pleasantly decorated and comfortable. Contrasting colours were used for bathroom and toilet areas. All toilets were dementia friendly with contrasting colours used for the toilet seat and grab rails. The corridors were clean and free of clutter and provided a safe environment for residents to mobilise. Handrails were provided and the layout allowed for circular movement for residents with dementia who like to actively walk around.

Pressure relieving mattresses and other aids were available, with records available to indicate servicing at appropriate intervals. Adequate space for storage of assistive equipment and space for the secure storage of personal belongings was available. Call bells were visible and easy to reach in all rooms. Overhead hoists were in place in all bedrooms. This formed part of the recent refurbishment. Laundry, cleaning and sluice facilities were appropriate to the size and layout of the premises.

The provider had stated in the self assessment that the centre was substantially compliant in this area. The inspector found that this outcome was substantially complaint.

Judgment:
Substantially Compliant

<table>
<thead>
<tr>
<th>Outcome 07: Health and Safety and Risk Management</th>
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<tbody>
<tr>
<td>Theme:</td>
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<tr>
<td>Safe care and support</td>
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<tr>
<td>Outstanding requirement(s) from previous inspection(s):</td>
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<tr>
<td>Some action(s) required from the previous inspection were not satisfactorily</td>
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Findings:
At the time of the last inspection it was found that further improvement was required regarding the completion of fire evacuation drills to ensure that all residents could be evacuated safely at all times. This had been partially addressed.

Review of the fire training records showed that all staff had undertaken training in fire safety. This was confirmed by staff. All staff spoken with knew what to do in the event of a fire. Fire drills were being completed regularly, and while attendance records were available, the records required to be more comprehensive to include as to whether a full or partial evacuation had been completed, what time it took to evacuate and whether there were any impediments to safe evacuation identified. No simulated fire drill had been completed to mirror a night duty scenario.

Fire records showed that fire equipment had been regularly serviced and the fire alarm had been serviced quarterly. The inspector found that all internal fire exits were clear and unobstructed during the inspection. At the time of inspection there were one resident who smoked. Safe procedures were in place to facilitate this. This was an action from the last inspection.

The action with regard to arrangements in place regarding the management of residents who smoked had been addressed. There was one resident who smoked resident in the centre at the time of this inspection. A smoking apron was available and a risk assessment was in place detailing supervision arrangements. Observation of residents was possible in the smoking room from the corridor.

Judgment:
Substantially Compliant

Outcome 12: Notification of Incidents

Theme:
Effective care and support

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

Findings:
At the time of the last inspection it was found that while a record of incidents occurring within the designated centre was maintained, there were examples whereby these were not notified to the Authority. This had been addressed.

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 report**

<table>
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<th>Mac Bride Community Nursing Unit</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0000647</td>
</tr>
<tr>
<td>Date of inspection:</td>
<td>04 &amp; 05/05/2017</td>
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<tr>
<td>Date of response:</td>
<td>13/07/2017</td>
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**Requirements**

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

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

**Outcome 01: Health and Social Care Needs**

**Theme:**
Safe care and support

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was poor evidence available that the care plans were made available to the resident and with their consent their relative.

**1. Action Required:**
Under Regulation 05(5) you are required to: Make the care plan, or revised care plan, prepared under Regulation 5 available to the resident concerned and, with the consent

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
This has been discussed with each registered nurse and an entry recorded in the communication book. Monthly audits will be conducted over the next 3 months to ensure that care plans are made available to residents and, with the consent of that resident or where the person-in-charge considers it appropriate, to his or her family.

Proposed Timescale: 31/08/2017

Outcome 02: Safeguarding and Safety

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Clear concise behaviour management care plans were not in place to provide direction to staff as to how to manage responsive behaviour. Plans failed to identify what triggers had been identified in the completed ABC (assessment, behaviour and consequences) charts. Residents with responsive behaviour had been seen by specialist services but there was poor evidence of their advice in the behaviour support plans.

2. Action Required:
Under Regulation 07(1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.

Please state the actions you have taken or are planning to take:
All behaviour management care plans have been reviewed and additional advice has been sought from specialist psychiatric services. Monthly audits will be conducted over the next 3 months to ensure that behaviour care plans are comprehensive and effective and if not effective will be reviewed constantly and further advice requested. The psychiatric team have been asked to do a training session for staff and to review the current behaviour plans.

Proposed Timescale: 31/08/2017

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
A documented risk assessment with control measures in place was not in place detailing these procedures. in the investigation of an allegation of abuse.

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

Please state the actions you have taken or are planning to take:
A risk assessment was completed during the HIQA inspection and presented to the HIQA inspector. This has been discussed with the General Manager for Older Peoples services...

Proposed Timescale: 05/05/2017

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:
A residents’ survey had been completed in 2015 and 2016. Similar issues with regard to for example, residents unaware of menu choices, unsure if they were asked their likes and dislikes was contained in the 2015 and 2016 questionnaires. No quality improvement plan had been enacted post either survey to review issues raised.

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

Please state the actions you have taken or are planning to take:
The residents survey is completed 12 monthly and was last conducted at the end of November 2016 and is therefore due again near the end of November 2017. Staff working in the kitchen are aware of residents likes and dislikes and the menu was updated in April 2017. The menu of the day is always written on the blackboard in the dining room and placed on each table. Residents with dementia and / or poor cognition may forget whether a conversation took place with them around the menu. A quality improvement plan has been completed. A site visit has been arranged for the PIC to visit another designated centre regarding their pictorial menus.

Proposed Timescale: 30/11/2017

Outcome 04: Complaints procedures

Theme:
Person-centred care and support
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy and procedure on complaints was confusing as both the provider and person in charge were documented as the complaints officer for the centre. The policy also failed to document details of the ombudsman.

5. Action Required:
Under Regulation 34(1) you are required to: Provide an accessible and effective complaints procedure which includes an appeals procedure.

Please state the actions you have taken or are planning to take:
The policy has been amended and was forwarded to the HIQA inspector.

Proposed Timescale: 05/05/2017

Outcome 05: Suitable Staffing
Theme: Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Safe moving and handling training was not current for some staff.

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

Please state the actions you have taken or are planning to take:
Moving and Handling training was arranged at the time of the HIQA inspection to take place on 22 & 23 May 2017. This was previously arranged for an earlier date but was cancelled by the external provider. Going forward, the training will be reviewed at the beginning of each year and rebooked for an earlier date (? 3 months) prior to the expiry of the certificates. The majority of staff have since received their training excluding those on annual leave, sick leave and night duty. Training is currently being booked for those staff.

Proposed Timescale: 31/12/2017

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:
The dining room did not have sufficient space to permit all residents attend at the same time and had limited space available to them.

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

**Please state the actions you have taken or are planning to take:**
We are looking at a few different options at the moment and these include:
1. To stagger lunch times and to offer 2 sittings. I am in the process of speaking to each resident to see if they would like a second sitting as they all appear to like the current times that meals are served.
2. To restrict access to the dining room at meal times via the doors outside my office and to place another 1-2 tables here.
3. The long term solution is to submit a business case to Grainne Cahill, Director of Estates, in December 2017 for consideration in 2018, from minor capital.
4. To use the sitting room in the interim as a second dining room for residents who currently are assisted with nutrition in the day room. I am in the process of speaking to each resident to see if they are happy with this suggestion.

I am going to trial one of the above for a period of 3 months depending on the decision of the residents.

**Proposed Timescale:** 30/09/2017

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

**Theme:**
Safe care and support

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fire drill records did not include details as to whether a full or partial evacuation had been completed, what time it took to evacuate and whether there were any impediments to safe evacuation identified.

No simulated fire drill had been completed to mirror a night duty scenario.

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

**Please state the actions you have taken or are planning to take:**
The PIC has compiled a list of dates between now and the 31st December 2017 when monthly fire drills will be conducted. The roster will be drafted around this list to ensure
that each staff member attends 2 fire drills every year. Each fire drill will include details as to whether a full or partial evacuation had been completed, what time it took to evacuate and whether there were any impediments to safe evacuation identified. The fire officer will be used as a resource during the annual fire training when training within the unit if advice is required. When fire drills are conducted during the day a night duty scenario will be given and evacuation with only 2 staff members will be discussed and how this could be achieved.

Proposed Timescale: To be reviewed monthly until 31st December 2017.