Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Drumbear Lodge Nursing Home
Centre ID:	OSV-0005312
Centre address:	Cootehill Road, Monaghan, Monaghan.
Telephone number:	047 84800
Email address:	phil@newbrooknursing.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Newbrook Nursing Home
Provider Nominee:	Philip Darcy
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	None
Type of inspection	Announced
Number of residents on the date of inspection:	51
Number of vacancies on the date of inspection:	1

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.

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 Quality 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 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:
27 October 2015 10:00	27 October 2015 18:30
28 October 2015 07:30	28 October 2015 15:00

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

Outcome	Our Judgment
Outcome 01: Statement of Purpose	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	Non Compliant - Moderate
Outcome 06: Absence of the Person in charge	Compliant
Outcome 07: Safeguarding and Safety	Non Compliant - Moderate
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Substantially Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Non Compliant - Major
Outcome 13: Complaints procedures	Non Compliant - Moderate
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	Non Compliant - Moderate

Summary of findings from this inspection

This was the eighth inspection of the centre by the Authority and was completed in response to a notification by Drumbear Nursing Home to cease trading and an application for registration of the designated centre by Newbrook Nursing Home. All required application documentation was received as required by the Authority. The person in charge will remain unchanged in the change of ownership process ensuring continuity for residents.

The inspector reviewed all outcomes in addition to progress with completion of the action plan from the last inspection of the centre on 19 November 2015 to assess compliance of the centre with the legislation and standards. A plan involving refurbishment and construction of an extension to ensure residents' privacy and dignity needs were met as described in the centre's statement of purpose in a multioccupany room and some twin room accommodation was forwarded to the Authority as part of the registration renewal documentation by the previous provider. It was scheduled for completion in December 2015 but had not been progressed to date. Mealtime arrangements did not facilitate all residents to dine in the dining room.

The inspector observed that staff engaged with residents positively and respectfully on the days of inspection. The inspector spoke with residents, the provider, person in charge and staff members. Some areas of dissatisfaction with the service in feedback in residents' and relatives' pre-inspection questionnaires is discussed in the relevant areas in the report.

Findings supported significant and sustained improvement was required in aspects of the governance and management of the centre including systems to monitor the quality and safety and quality of life for residents in the centre.

Arrangements were in place to ensure infection control and prevention responsibilities and standards were met.

Governance and management arrangements had been strengthened since the last inspection in August 2014 however, the system in place to review and monitor the quality and safety of care and quality of life of residents required further improvement to ensure all areas of deficit were identified and actioned with positive outcomes for residents.

Some areas of fire safety and risk management required improvement. Inspectors found evidence to indicate that further staffing review was required to ensure the staffing skill levels and skill mix was adequate to meet the needs of residents. While a training programme was in place, some staff had not attended mandatory training requirements.

Improvements were required in the documented records to be maintained in the centre as required in schedules 2, 3, and 4 of the regulations.

Areas of residents' medication prescriptions did not meet legislative requirements on this inspection.

Some residents assessed needs were not informed by adequate care plans. Review of a sample of residents' care documentation did not provide adequate evidence to support the level of some residents' participation in the social programme met their interests and capabilities.
Residents had access to medical and allied health professional expertise to support their health needs.

The action plan at the end of this report identifies areas where improvements are required to comply with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland.

Compliance with Section 41(1)(c) of the Health Act 2007 and with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Quality 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:
There was a written statement of purpose available that accurately describes the service provided in the centre and is clearly demonstrated in practice.

A copy of the centre's statement of purpose and function dated 01 September 2015 was forwarded to the Authority. This document was reviewed and contained all information as required by schedule 1 of the Regulations.
The statement of purpose and function accurately described the range of resident needs that the designated centre meets and the services provided.

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

Findings:

The new provider, Newbrook Nursing Home demonstrated arrangements for implementation of a robust governance and management structure that assumed full responsibility and accountability for the service. The inspector observed that arrangements were in place to ensure a smooth transition of ownership to the new provider without undue disruption to the service for current residents and staff. A new Statement of Purpose was forwarded to the Authority as part of the registration documentation referencing continuity of the current service for residents.

The inspector observed that inter level staff communication forum arrangements required improvement.

The inspector was informed that the current person in charge will remain in post ensuring continuity. There were robust arrangements in place including a practice development co-ordinator, training officer, risk and documentation management systems to support the person in charge in her role as part of the management structure of Newbrook Nursing Home group.
The inspector observed on the days of inspection that while there were management systems in place for monitoring some key aspects of quality and safety which were improved since the last inspection in November 2014, further improvement was required in this process to ensure all aspects of the service is regularly reviewed in terms of quality and safety and quality of life for residents. In addition, some audits completed failed to identify some deficits identified on inspection, for example in medication management as discussed in outcome 9.

The Authority were advised that refurbishment of a multioccupany room and an extension to the premises would be completed by December 2015 to address non-compliances with the legislation as found on the last inspection in November 2014. This action is a condition of registration as granted in February 2015 and has not been completed to date. This finding is discussed further in outcome 12. Other non-compliances not satisfactorily addressed since the last inspection in November 2014 included care planning and staffing levels/skill mix review. These findings indicated that governance and clinical leadership required significant and sustained improvement.

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

Findings:
Inspectors found that there was a residents' guide available to inform residents of the services available to them. Review of the activities as presented was required to ensure clarity in this document. The costs of services to residents outside of the nursing home fee were not stated so as to facilitate residents' informed choice if they wished to avail of same.

As part of the improvements made since the last inspection in November 2014, the various recreational activities available to residents and their location were clearly displayed on a white board by the dining room on a daily basis. The inspector also observed other items of interesting information displayed at various points around the centre to keep residents informed.

Each resident had a contract of care signed by them or their next of kin. A sample of agreed resident contracts was reviewed by the inspector. While improved, they required further review to ensure they meet the requirements of the legislation.

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 of the centre is Caroline McAree. She was appointed in this role in August 2010. She is a registered general nurse with An Bord Altranais agus Cnáimhseachais na hÉireann. She has experience in caring for older people as required by the Legislation. The person in charge was in the role of person in charge of a residential centre for older people for 1 year in a previous employment. The person in charge has maintained her professional development with attendance at study days on dementia, palliative care, infection control and prevention, nutrition among others. The person in charge was awarded a Bachelor of nursing
degree in 2004.

The person in charge demonstrated that she is engaged in the governance, operational management and administration of the centre on a full-time basis. The person in charge was knowledgeable about resident's needs and their individual choices on this inspection. Residents knew the person in charge and the inspector observed residents

consulting with her over the days of inspection.
During this inspection the person in charge demonstrated that she was aware of the Regulations, the Authority's Standards and her responsibilities as person in charge of the centre. The person in charge facilitated the inspection and information was easy to retrieve and was managed with appropriate attention to security of residents' personal information

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

Findings:
The designated centre maintained a directory of residents which did not contain all of the necessary information as specified in Schedule 3 Paragraph (3).

A restrictive practice log was not maintained in the designated centre to reference use of bedrails that restricted residents' access and did not include all of the information required in Schedule 3 Paragraph (4) (g).
Daily evaluation of resident care was not consistently linked to care plans and did not comprehensively inform resident progress as required by Schedule 3, Paragraph 4(c)
Each medication to be given in crushed format was not individually signed by a medical practitioner in the relevant prescription records reviewed as required in Schedule 3 Paragraph 4 (d).

The new provider, Newbrook Nursing Home had arrangements in place to implement the relevant changes to Schedule 5 policy and procedural documentation.
Improvements were required in fluid management documentation format to ensure residents' hydration needs were accurately recorded as required by Schedule 5 documentation.

Judgment:

Non Compliant - Moderate

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 and person in charge were aware of their responsibility to notify the Chief Inspector of the absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during an absence greater than 28 days.
The current arrangement in place is that the outgoing provider nominee would assume the role of person in charge in the event of the person in charge being absent for more than 28 days. As this arrangement is now ceasing, the new provider nominee advised the inspector that recruitment procedures were underway to appoint a clinical nurse manager grade to support the person in charge in her role and to deputise in her absence. The person in charge has not been absent from the centre for more than 28 days to date.

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

Findings:
There were measures in place to safeguard and protect residents. The inspector

reviewed the policy informing management of allegations of abuse and found that it included referral details for the elder abuse social worker and procedures for staff to take if an allegation is made against a senior member of staff. Staff spoken with by the inspector on the days of inspection were knowledgeable regarding procedures for protection of vulnerable residents including their reporting responsibilities. Staff training in elder abuse prevention, recognition and management was facilitated every two years.

Residents spoken with told inspectors they felt safe in the centre. The entrance and exit doors were secure yet accessible to residents. A visitors log was in use to monitor the movement of persons in and out of the building which the inspectors observed to be completed. Closed circuit television monitoring (CCTV) was in operation in the centre on entrance doors and in corridors. A policy was available to inform use and notices on operation of this monitoring were displayed. The inspector observed staff - resident interactions on the days of inspection and found them to be caring, respectful and supportive throughout.

The inspector observed that the majority of staff in the centre had attended training in non-violent crisis intervention/managing challenging behaviour. The inspector was advised by the person in charge that none of the current residents in the centre experienced challenging behaviour. This finding was confirmed with no incidents recorded in the incident and accident records.
Most staff had completed training in care of residents with dementia care needs since the last inspection.

A number of residents were using bedrails with protective bumpers. However, the use of bedrails was not in line with some aspects of the National restraint policy. Review of residents' documentation by the inspector did not evidence adequate assessment of need or detail of alternatives trialled before implementation of bedrail use. There were six residents recorded in the restraint register using bedrails however, this number did not fully reflect all residents observed by the inspector using bedrails on the days of inspection. The inspector was told that use of many bedrails by residents was for the purpose of enabling their mobility while in bed. However, the equipment as observed was not suitable for this purpose in some cases as some residents' independent access out of their beds was restricted because bedrails extended the full length of the beds and residents could not disengage them independently or independently operate their call-bells. However, there was evidence of bedrail disengagement schedules recorded for each resident using bedrails. The inspector also observed that a number of residents who were assessed as being at risk of falling had alarm mats and low-low beds in place to promote their safety. A small number of residents used lap-belts while in wheelchairs. This finding was not recorded in the restraint register.

Judgment:
Non Compliant - Moderate

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:
The inspector found on this inspection that the health and safety of residents, visitors and staff was generally promoted and protected. The staff training records evidenced attendance of all staff at twice annual fire training. Each member of staff had participated in a fire evacuation drill. There were detailed records of each evacuation drill completed. A fire prevention checking procedure was in place completed by the staff member responsible for maintenance in the centre. While checking that fire exits were clear of obstruction was checked regularly, this was not done on a daily basis. The inspector observed that all fire exits were clear of obstruction on the days of inspection. The inspector also observed that blinds fitted over a designated fire exit door in the sitting room were removed to ensure no potential obstruction to safe exit if required was present. In addition, fire exit doors were fitted with thumb-turn locks to facilitate ease of opening in an emergency. Service records of fire safety equipment including the fire alarm were in place.

The centre's safety statement was reviewed on 18 November 2014. A Risk Assessment Policy was available and informed risk management in the centre. There was evidence of ongoing risk identification, assessment and implementation of controls to mitigate level of risks found. There was also evidence that controls in place for a number of risks identified on the last inspection in November 2014 were strengthened. While grab rails were fitted in residents' en suite showers and toilets following occupational therapy assessment and recommendations since the last inspection, use of portable chair type raisers continued to be placed over some toilets which posed a risk of overbalance to some residents.

There was evidence that resident falls was identified as an area of increased risk. Auditing of resident falls was completed on a monthly basis to ensure falls management plans were effective in mitigating assessed falls risks. There was previous evidence that the person in charge reviewed audit findings of greater numbers of falls occurring during night-time hours, particularly during the period 20:00 to 02:00hrs in terms of staffing levels. However, the inspector found on review of documented resident fall incidents from 01 January 2015 to end of October 2015 that further review was required as previous findings as referenced had not significantly changed.

There were measures in place to control and prevent infection. Staff were observed to complete hand hygiene practices as appropriate on the days of inspection. Environmental cleaning procedures were of a good standard with a colour coded flat mopping procedure in place for cleaning floors and cloths were available for surface cleaning reflected evidence based infection prevention and control standards. Waste management procedures also reflected evidence based practice. Cleaning staff spoken with were knowledgeable in relation to infection control and prevention. There was an

infection prevention and control policy in place dated 01 May 2015 however this required some further review to reference the cleaning procedures as used and management of one type of infection as found in the centre. Assessment was also required in relation to adequacy of the availability of hand hygiene dispensers and hand hygiene facilities in the cleaner's room.

Judgment:
Non Compliant - Moderate

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

Findings:
Written operational policies relating to the ordering, prescribing, storing and administration of medicines to residents were in place. However, medication prescribing practices were not in line with the legislation. Adequate procedures including storage were in place for management of controlled medications as required.
Transcription of medications was undertaken by registered nurses in the centre. Procedures were in place in relation to same and practices were observed to be in line with professional standards.

The inspector examined a sample of medication prescription sheets and administration records.The medication prescription sheets examined were current. However, the inspector observed that some of the medication prescription sheets examined did not contain a route and signature for each medication order. Maximum PRN ('as required') medication dosages over a 24hr period was not stated in some prescriptions. Instruction to crush medication was not individually recorded against relevant medications and was recorded as a general order on some prescriptions reviewed. The inspector also observed that one medication was prescribed for regular and for PRN administration for one resident. Therefore, these prescription orders were not complete authorisations to administer medications as per the Medicinal Products (Prescription and Control of Supply) Regulations (Amendment) 2007. This finding is addressed in outcome 5.

Medication management audits were completed regularly and results were made available to the inspector. However, as detailed in Outcome 02: Governance and Management, these medicines management audits did not adequately cover all aspects of the medicines management cycle.

Residents' photographs were clear and fixed on each prescription for the purposes of

checking procedures during medication administration. Drug allergies, date of birth and each resident's GP details were recorded. Medication administration was observed by the inspector to be in line with professional standards.

Judgment:
Non Compliant - Moderate

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:
The provider and person in charge were aware of their legal requirements regarding notifications to the Chief Inspector including serious injury to residents.
To date and to the knowledge of the inspector, all relevant incidents had been notified to the Chief Inspector as required.

Quarterly notification requirements were forwarded including details of bedrail restraint use. However, did not include details of lap-belts used in the centre

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

Findings:

There was fifty one residents in the centre on the days of inspection. Thirty four residents were assessed as having high dependency needs, thirteen had medium dependency needs and four had low dependency needs. Twenty residents had dementia care needs and a further fifteen residents had symptoms of dementia including confusion. While there were a number of residents with comprehensive care needs as observed on inspection, the dependency assessment tool used did not include a level for maximum dependency. While residents needs were generally met, this assessment tool requires review to ensure the staffing tool used accurately informs staffing level/skill mix requirements.

Each resident had care plans developed from an assessment of their need which was regularly reviewed. The inspector reviewed a sample of care plans and care documentation. A variety of assessment tools were used to evaluate residents' progress and to assess levels of risk for deterioration. For example, vulnerability to falls with corresponding actions to take in response to level of assessed risk, dependency levels, nutritional risk assessment and moving and handling assessments which were updated every four months thereafter. A pressure related skin damage risk assessment tool in use revised since the last inspection informed the level of risk as reflected by the score calculated and care as required.

While all resident needs were identified appropriately in the sample reviewed. the inspector observed that care planning in general required improvement and refinement. For example, some care interventions to meet individual assessed needs was not comprehensive and in some instances there were a number of care plans to address the same assessed resident need. While daily evaluation of resident care completed by nursing staff was informative in many cases, it was not consistently linked to care plans and did not comprehensively inform resident progress. This finding is addressed in outcome 5.

Residents had documented access to general practitioner (GP) services in addition to specialist services to support their mental health needs where required. While the person in charge reported challenges in accessing some allied health professional services for residents, the documentation referenced that residents were facilitated with appropriate access to these services.
In a sample of records reviewed, the inspectors noted that consultations and assessments with care recommendations were recorded to support referral as appropriate. While no residents required palliative care services on the day of inspection, access to this service was confirmed.

The inspector observed that work was completed and further work was in progress to improve residents' access to meaningful recreational and social activities in line with their interests and capabilities. This finding is discussed further in outcome 16.

There were two residents under 65years of age. There were tailored plans of care developed and implemented for these residents that met their care and activation needs. Both residents had assistive equipment in place to support their mobilisation needs.

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

Findings:
Residents' accommodation in the centre is provided at ground floor level throughout. As part of the centre's renewal of registration procedure in February 2015, the provider forwarded a plan to the Authority to restructure the six bedded multi occupancy room and insufficient storage space by 31 December 2015. The provider advised the inspector on this inspection that structural work had not commenced to date. Following the last inspection in November 2014, the provider reviewed the layout of some twin bedrooms that did not adequately meet the privacy and dignity needs of some residents especially those with increased dependency needs. The inspector observed that tracking for some bed screen privacy curtains was repositioned to enhance available privacy space adjacent to residents' beds and access to en suite facilities was improved by repositioning of furniture. Review on these bedrooms on this inspection evidenced adequate access for residents not requiring personalised assistive chairs, however the inspector observed that access to en-suite facilities and the privacy and dignity needs of other dependant residents residing in these bedrooms was not assured.

The inspector observed that resident equipment servicing records reviewed were current.

The multi occupancy bedroom accommodates six residents and with an en suite shower, toilet and wash basin provided. Glass window panels are fitted in the wall between this room and a corridor on each side of the entrance door to the room. The inspector was told and observed that interim measures were taken since the last inspection to obscure view at all times during residents' personal care activities on the day of inspection. The layout of this accommodation was clinical in style and did not ensure that each resident had adequate private space which they could personalise. Most residents in this area had no personal shelf space other than the top of their lockers or wardrobe for displaying or storing their personal items. One television was available for viewing by the six residents which did not promote personal choice or autonomy. As previously stated a refurbishment plan forwarded to the Authority was not progressed as

scheduled.

- The size and layout of the dining room and dining arrangements did not ensure each resident could dine in the dining room as discussed in outcome 15.
- While there was a system in place with use of containers to segregate clean and soiled clothing/linen in the centre's laundry facility, worktop space for this purpose was not provided as recommended by the National Standards.
- While a cleaner's room was available with sluicing facilities, appropriate hand hygiene equipment was not available in this area.
- There was insufficient storage in the centre for residents' equipment.

There were two sitting rooms and one dining room, all of which were used by residents. Residents had access to a secure, attractive internal courtyard. Assistive equipment was provided to meet the assessed needs of the residents including standing and lifting hoists, pressure relieving mattresses and cushions, wheelchairs and walking frames.

A full-time member of staff carried out maintenance of the centre. There was a procedure in place for identifying maintenance issues including faults which was signed-off on completion. This arrangement facilitated quality assurance and identification of areas requiring review.

Judgment:
Non Compliant - Major

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

Findings:
There was a complaints procedure in place in the centre. Actions required to update the policy following the last inspections were satisfactorily completed. An independent appeal process was in place.

The inspector reviewed the centre's complaints log and observed that there were no complaints recorded for 2015. On the last inspection in November 2014, documented complaints were processed in line with the policy information with the exception of documentation to ensure the complainants were satisfied with the outcome. There were procedures in place to ensure documentation was complete.

Although not routinely documented, the person in charge told the inspector that any day

to day expressions of dissatisfaction with any aspect of the service were addressed on receipt.
Feedback in the Authority's pre-inspection questionnaires referenced that the majority of residents and their next of kin expressed their satisfaction with the service and all respondents knew who to make a complaint to. However, However, some respondents to pre-inspection questionnaires stated some dissatisfaction with some aspects of the service including some delays experienced with staff responding to their call-bell. In addition, the residents' meeting minutes referenced where some resident attendees used the forum to express their personal dissatisfaction about aspects of the service. There was insufficient evidence to support that these areas of dissatisfaction were addressed through the complaints process. This finding requires improvement.

Judgment:
Non Compliant - Moderate

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:
Inspectors were told by the person in charge that there were no residents in receipt of end of life care on the days of this inspection. A review of a sample of residents' care plans evidenced that their end of life wishes were discussed and documented where they wished to disclose this information. Members of the local clergy from the various religious faiths provided pastoral and spiritual support to residents who were at the end stage of their lives. There was a policy document available to inform residents' end of life care in the centre. Palliative care services were available on referral to assist with promoting residents' comfort needs. Most staff had attended training on end of life care procedures. In addition staff had attended training on management of medication pumps for administration of medication as part of the palliative care service. A small oratory was available to residents which they could spend time in if they wished.

The centre had arrangements in place to provide accommodation and refreshments for relatives of residents at the end stage of their lives to facilitate residents to have their families with them at this time. The person in charge confirmed that residents residing in twin or the multioccupany bedroom would be provided with single room accommodation at the end stage of their lives if possible.

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:
There was satisfactory evidence that residents were provided with adequate fluid and dietary intake to meet their needs on the day of inspection. Fresh water was available in each resident's bedroom and in communal areas. Staff were observed to engage in monitoring and encouraging residents to take fluids. Some improvements were required in fluid management documentation as discussed in outcome 5.

The inspector found that each resident's individual nutritional and dietary needs were generally met and that they were offered a nutritious and varied diet that provided them with choice of a hot dish at each mealtime. This choice was displayed in the dining room. Residents' weights were monitored. The inspector reviewed one resident's documentation regarding an unintentional weight loss of 7kg since August 2015. Inspector's findings supported a requirement for improvement in recommended food fortification procedures, staff education in this area and subsequent record-keeping. While an accredited tool was used to assess residents' nutritional needs, the recommended actions informed by the risk score were not consistently applied as recommended. The inspector observed residents at mealtime and found that those that required assistance received same in a dignified and discrete way by adequate members of staff who were assigned to ensure residents were appropriately assisted if necessary.

The chef was aware of and accommodated residents with specific nutritional preferences. The inspector observed that she had copies of the recommendations made by speech and language and dietetic therapy services which she stated she referenced when preparing individual resident meals. Care plans were in place to inform care of residents with nutrition and hydration needs.

The dining room had accommodation for 28 residents, a further of residents were served their meals in the day room. The remaining residents ate their meals in their bedrooms which the inspector was told was their choice. As discussed in outcome 12, this finding requires review to ensure all residents can avail of the dining experience in the dining room if they wish. Residents spoken with by the inspector and residents who provided feedback in the Authority's pre-inspection questionnaires told the inspectors that they enjoyed the food provided in the centre and spoke about the chef in complimentary terms.

The inspector observed that the dining room was closed for frequent periods outside of mealtimes, this finding requires review to ensure residents can access the dining room if they wish and is addressed in outcome 16.

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

Findings:
The inspector observed that in overall terms, residents were enabled to make choices about how they lived their lives in a way that generally reflected their individual preferences and diverse needs. However, the layout and space available in some areas of the premises including the dining room, the multioccupany and some twin bedrooms as discussed in outcome 12 did not ensure some residents' choice, privacy and dignity needs were met as set out in the centre's statement of purpose and function. A premises restructuring plan forwarded to the Authority as part of the required registration renewal documentation following the last inspection in December 2014, however, this plan has not been progressed to date.

While some improvements have been made to the layout and space available in some twin bedrooms since the last inspection, the needs of residents using individualised assistive chairs was not adequately met in a number of these bedrooms. The multi occupancy room also had glass window panels located in the wall between the room and a corridor on either side of the door to this room. An adhesive material was placed on the surface of the glass to obscure view into the rooms as an interim measure pending completion of restructuring work.

Mass was celebrated in the centre's communal sitting room on a monthly basis with weekly distribution of communion. However, a number of residents expressed their dissatisfaction with the frequency of Mass in feedback in the Authority's pre-inspection questionnaires. One resident expressed a wish for assistance to occasionally attend Mass in the local cathedral. There were arrangements in place to ensure the needs of residents of non catholic faiths were met. The inspector observed that the dining room

was closed for frequent periods outside of mealtimes, this finding requires review to ensure residents can access the dining room if they wish and is addressed in outcome 16. .

While there evidence that residents were generally consulted about the running of the centre, some opportunity for improvement was available. There was a residents' forum in place, meetings were infrequent and records of two meetings held for 2015 were available. There was low attendances by residents and arrangements were not in place to routinely circulate the minutes for other residents information. As discussed in outcome 13, the residents' meeting minutes referenced where some resident attendees used the forum to express their personal dissatisfaction about aspects of the service. There was insufficient evidence to support that these areas of dissatisfaction were addressed through the complaints process.

Independent access to the internal courtyard was in place to facilitate vulnerable residents with safe access outside the centre.
An advocate was available to residents to support them to make informed decisions about areas that impacted on them.

The inspector observed that improvements had been made in the area of residents' recreational activity provision since the last inspection in November 2014. The inspector observed positive engagement by many residents who were facilitated to engage in meaningful activities according to their interests and capabilities. The variety of activities provided were clearly displayed and convened in different venues throughout the centre giving residents an opportunity to choose the activity that most interested them in a comfortable environment that was not crowded. The needs of residents with dementia was met with opportunity to participate in an accredited sensory focused programme that some staff had been trained to facilitate. Residents who choose to remain in their bedrooms were provided with options including hand massage, newspaper and poetry reading facilitated by the activity co-ordinators or other staff. There was evidence from feedback in pre-inspection questionnaires and the inspector's discussions with some residents that they were making choices about activities they attended. The inspectors found that staff spoken with were knowledgeable regarding residents' past occupations and interests.

Each resident, including residents who chose to remain in their bedrooms had an activity assessment in place. While improved since the last inspection, some further work was possible to ensure each resident was facilitated to participate in activities that meet their individual interests and needs especially residents who remained in their bedrooms. This was evidenced by documentation in daily progress notes. these evaluations did not adequately inform whether participation in scheduled activities resulted in positive outcomes for some individual residents as part of their social care.

There were two residents under 65years of age. There were tailored plans of care developed and implemented for these residents to meet their care and activation needs.

Residents' confirmed that they had regular visitors and could choose where they would like to meet them. A quiet room with comfortable seating was available in addition to the two sitting rooms.

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):
No actions were required from the previous inspection.

Findings:
Since the last inspection in November 2014, access for residents to their wardrobe space in some twin rooms had been reviewed. While improved, independent access in some of the twin rooms was observed on this inspection to continue to be hindered for some residents who were mobile and absent for some other residents using assistive equipment. This finding required further improvement.

There was a policy to inform management of residents' personal property and possessions available. A record of each resident's property was completed to ensure possessions were recorded. There were no incidents or complaints recorded referencing loss or damage to residents' clothing. Residents spoken with told the inspector and confirmed in the Authority's feedback pre-inspection questionnaires that their clothing was always managed to their satisfaction. The inspectors observed that clothing worn by residents was clean, in good condition and stored neatly in wardrobes and drawer units. Items of residents clothing viewed by the inspectors had the residents identification on them.

The centre has a laundry on-site and residents clothing was laundered by a designated staff member. Linen collection skips were available that appropriately segregated used linen in line with the national policy. While segregation of clean and soiled linen/clothing was done with use of liner containers, a worktop was not available in the laundry for this purpose as recommended by the National Standards. This finding is also discussed in outcome 12.

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

Findings:
A copy of the staffing roster was provided and was reviewed by the inspector. It referenced that there is a registered nurse on duty at all times in the centre. On the days of inspection, the duty rota accurately reflected staff working in the designated centre. The provider and person in charge demonstrated that they had reviewed the staffing provided in response to inspection findings from the last inspection by the Authority.

The inspector assessed staffing levels and skill mix on the days of inspection and found that further review was required.
- based on a review of resident accidents and incidents
- based on feedback from residents in the Authority's pre-inspection questionnaires referencing some delay in staff response to some residents' call bells.
- based on a review of resident dependency levels and care needs

The names and corresponding personal identification numbers for all staff nurses employed in the designated centre was available and confirmed that each were registered with An Bord Altranais agus Cnáimhseachais na hÉireann.

The inspector observed that inter level staff communication forum arrangements required improvement.

A staff training matrix was maintained and recorded staff attendance at training to support their professional development. While staff were observed to practice safe moving and handling procedures on the days of inspection, all staff had not completed up to date mandatory training in this area. Mandatory refresher staff training in protection of vulnerable adults was scheduled for all staff in November 2015.

Residents spoken with by the inspector were complimentary of the staff team. The inspector found staff spoken with to be knowledgeable regarding their roles and responsibilities in relation to residents' care and preferences.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Catherine Rose Connolly Gargan
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[1]

Centre name:	Drumbear Lodge Nursing Home
Centre ID:	OSV-0005312
Date of inspection:	27/10/2015 and 28/10/2015
Date of response:	27/11/2015

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 02: Governance and Management

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems to ensure that the service provided is safe, appropriate, consistent and effectively monitored were not adequate.

1. 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.

[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:
In line with new company policy a quarterly review of quality and safety will be completed. The introduction of the company online risk management system will reinforce quality improvement through robust risk management, audit and incident reporting. The results of these will be used to improve practice.

Care planning will be moving to a computerised system.

This will address compliance in care planning.

A further review of staffing levels and skill mix will be undertaken by the new owner.

We will implement the plan of the previous provider, Drumbear Lodge Nursing Home Ltd, to address the multiple occupancy room. However the timeframe for completion will be extended to the 31st March 2017.
Proposed Timescale: 31st July 2016 and 31st March 2017

Proposed Timescale: 31/03/2017

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The inspector observed that staff communication forum arrangements required improvement.

2. Action Required:
Under Regulation 23(b) you are required to: Put in place a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
A schedule has been developed for monthly staff meetings.

All meetings will have minutes taken and available for inspection.

Proposed Timescale: 31/01/2016

Outcome 03: Information for residents

Theme:
Governance, Leadership and Management

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

Clarification was required to distinguish activities provided and services available to residents including indication of fees where appropriate

3. Action Required:
Under Regulation 20(2)(a) you are required to: Prepare a guide in respect of the designated centre which includes a summary of the services and facilities in the centre.

Please state the actions you have taken or are planning to take:
The residents guide and contract will include all activities and services and will clearly document additional fees and costs of the activities and services to the residents.

Proposed Timescale: 29/02/2016

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Clarity was required to ensure contract documentation included details of any other service which the resident may choose to avail of but which is not included in the Nursing Home fee.

4. Action Required:
Under Regulation 24(2)(d) you are required to: Ensure the agreement referred to in regulation 24 (1) includes details of any other service which the resident may choose to avail of but which is not included in the Nursing Homes Support Scheme or which the resident is not entitled to under any other health entitlement.

Please state the actions you have taken or are planning to take:
The residents guide and contract will include all activities and services and will clearly document additional fees and costs of the activities and services to the residents.

Proposed Timescale: 29/02/2016

Outcome 05: Documentation to be kept at a designated centre

Theme:
Governance, Leadership and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A restrictive practice log was not maintained in the designated centre to reference use of bedrails that restricted residents' access and did not include all of the information required in Schedule 3 Paragraph (4) (g).

Daily evaluation of resident care was not consistently linked to care plans and did not comprehensively inform resident progress as required by Schedule 3, Paragraph 4(c)

Each medication to be given in crushed format was not individually signed by a medical practitioner in the relevant prescription records reviewed as required in Schedule 3 Paragraph 4 (d).

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:
a)There is a restrictive practice log in the nursing home which includes all information required in Schedule 3 Paragraph (4) (g). This also includes lap-belts.

b)Care planning will be moving to a computerised system. This will address compliance in care planning. This will include training in care planning.

c)The Don has spoken to the GP's in relation to this matter and requested that they individually sign medications that require crushing. This will remain under review.
Proposed Timescale:
a)And c) completed 24TH November 2015.
b)31st July 2016.

Proposed Timescale: 31/07/2016

Outcome 07: Safeguarding and Safety

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The use of bedrails was not in line with some aspects of the National restraint policy.

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

Please state the actions you have taken or are planning to take:
All restrictive devices used in the nursing home will be reviewed and reassessed in line with National Restraint Policy.

Proposed Timescale: 31/12/2015

Outcome 08: 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:
Risk assessment of a small number portable chair type raisers used over toilets was not completed to ensure controls were in place to mitigate risk of overbalance to some residents.

7. 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 assessments for portable chair type raisers over toilet seat will be completed. Arrangements will be put in place for weekly monitoring.

Proposed Timescale: 31/01/2016

Theme:
Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The infection prevention and control policy in place required some further review to reference the cleaning procedures as used and management of one type of infection as found in the centre.

Assessment was also required in relation to adequacy of the availability of hand hygiene dispensers and hand hygiene facilities in the cleaner's room.

8. 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:
a)The infection control Policy will be reviewed to include cleaning procedures and the management of the infection found in the centre.
b)An audit of available hand hygiene dispensers has taken place and the required number will be obtained and placed at point of care to ensure Infection Control Practices are in line with best practice.

Proposed Timescale: 31/12/2015

Theme:

Safe care and support

The is failing to comply with a regulatory requirement in the following respect:
While checking that fire exits were clear of obstruction was checked regularly, this was not done on a daily basis.

9. 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:
Checking of fire exits to ensure they are clear of obstruction is now part of the daily checks.

Proposed Timescale: 24/11/2015

Outcome 09: Medication Management

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The medication prescription sheets examined did not contain
- a route and signature for each medication order
- maximum PRN ('as required') medication dosages over a 24hr period was not stated in some prescriptions
- instruction to crush medication was not individually recorded against relevant medications and was recorded as a general order on some prescriptions reviewed.
- one medication was prescribed for regular and for PRN administration for one resident.

10. Action Required:
Under Regulation 29(5) you are required to: Ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.

Please state the actions you have taken or are planning to take:
A review of our current MMARS prescription form will be conducted. Changes will be made to improve compliance with the above regulatory requirements.

The DON will meet with the GP's in relation to the above this matter and requested that they individually sign medications that require crushing. This will remain under review.
Proposed Timescale:
a)30th June 2016.
b)24th November 2015.

Proposed Timescale: 30/06/2016

Outcome 10: Notification of Incidents

Theme:
Safe care and support

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Quarterly notification requirements did not include details of lap-belts used in the centre

11. Action Required:
Under Regulation 31(3) you are required to: Provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of any incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.

Please state the actions you have taken or are planning to take:
Going forward details of use of lap-belts will be part of the quarterly notifications.

Proposed Timescale: 31/01/2016

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:
Some care interventions to meet individual assessed needs was not comprehensive and in some instances there were a number of care plans to address the same assessed resident need.

12. Action Required:
Under Regulation 05(3) you are required to: Prepare a care plan, based on the assessment referred to in Regulation 5(2), for a resident no later than 48 hours after that resident's admission to the designated centre.

Please state the actions you have taken or are planning to take:
All residents are assessed within 48hours of admission to the nursing home.
A review of all care plans will be conducted with the introduction of a computerised system. This will eliminate duplication of care plans.

Proposed Timescale: 31/07/2016

Theme:

Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The dependency assessment tool requires review to ensure the resources for resident care is reflected.

13. Action Required:
Under Regulation 06(1) you are required to: Having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care for a resident, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Please state the actions you have taken or are planning to take:
Barthel 2 index has been introduced which includes a level for maximum dependency. In turn all residents' dependency levels will be reassessed

Proposed Timescale: 31/12/2015

Outcome 12: Safe and Suitable Premises

Theme:
Effective care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
- access to en-suite facilities and the privacy and dignity needs of other dependant residents residing in some twin bedrooms was not assured.
- a multi occupancy bedroom layout did not ensure that each resident had adequate private space which they could personalise.
- The size and layout of the dining room and dining arrangements did not ensure each resident could dine in the dining room
- The laundry facility required review. - While a cleaner's room was available with sluicing facilities, appropriate hand hygiene equipment was not available in this area.
- There was insufficient storage in the centre for residents' equipment.

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:
We will implement the plan of the previous provider, Drumbear Lodge Nursing Home Ltd, to address the multiple occupancy room, storage space, laundry area and dining area. We will also reassess all twin rooms to ensure that the privacy and dignity of the residents is met. However the timeframe for completion will be extended to the 31st March 2017.

Proposed Timescale: 31/03/2017

Outcome 13: Complaints procedures

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was insufficient records of investigation of dissatisfaction expressed by residents.

15. Action Required:
Under Regulation 34(1)(f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.

Please state the actions you have taken or are planning to take:
Going forward any dissatisfaction expressed by residents will be documented as a Complaint and will be processed as per Complains Policy.

Proposed Timescale: 24/11/2015

Outcome 16: 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:
The layout and space available in some areas of the premises including the dining room, the multioccupany and some twin bedrooms negatively impacted on some residents' choice, privacy and dignity.

Choice for residents to independently access the dining room was hindered due to a practice of closing the dining room between mealtimes.

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

Please state the actions you have taken or are planning to take:
We will implement the plan of the previous provider, Drumbear Lodge Nursing Home Ltd, to address the multiple occupancy room, storage space, laundry area and dining area. We will also reassess all twin rooms to ensure that the privacy and dignity of the residents is met. However the timeframe for completion will be extended to the 31st March 2017.

The dining room will not be closed between mealtimes.
Proposed Timescale: 30th November 2015 and 31st March 2017

Proposed Timescale: 31/03/2017

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While improved since the last inspection, some further work was possible to ensure each resident was facilitated to participate in activities that meet their individual interests and needs especially residents who remained in their bedrooms.

Residents' documentation did not adequately inform whether participation in scheduled activities resulted in positive outcomes for some individual residents in terms of meeting their interests and capabilities.

17. 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:
Activities within the Nursing Home will be reviewed and the Role of the Activities person will include ownership and responsibility for assessment of care planning activities that will be person centered and relevant to the resident resulting in positive outcomes. Such outcomes will be documented in the care plan and will be reviewed on a regular basis.

Proposed Timescale: 30/06/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Improvements were required in meeting arrangements in place to ensure residents were consulted about the running of the centre.

18. 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:
a)Residents meetings will be scheduled on a 3 monthly basis and this will be an opportunity for Residents to be consulted and participate in the organisation of the Nursing Home.

b) A quarterly Residents magazine will be commenced.
Proposed Timescale: a) 31st January 2015 b) 30th September 2016

Proposed Timescale: 30/09/2016

Theme:
Person-centred care and support

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Some residents were not satisfied with the arrangements in place for them to practice their religion

19. Action Required:
Under Regulation 09(3)(e) you are required to: Ensure that each resident can exercise their civil, political and religious rights.

Please state the actions you have taken or are planning to take:
All residents are encouraged to practice their religious beliefs and every effort is made to facilitate this. Communion is distributed on a daily basis.
Mass is celebrated on a monthly basis in the nursing home and cannot be secured on a more regular basis due to parochial commitments within the community. DON has spoken to local priests and this remains an issue under constant review.
Relatives are encouraged if they can to take their loved one to Mass and or other religious services in the community.

Proposed Timescale: 24/11/2015

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:
While improved, independent access to clothing in wardrobes in some of the twin rooms was hindered for some residents who were mobile and absent for some other residents using assistive equipment.

20. 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:
We will also reassess all twin rooms to ensure that the privacy and dignity of the residents is met. However the timeframe for completion will be extended to the 31st March 2017.

Proposed Timescale: 31/03/2017

Outcome 18: Suitable Staffing

Theme:
Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Further staffing review was required.
- based on a review of resident accidents and incidents
- based on feedback from residents in the Authority's pre-inspection questionnaires referencing some delay in staff response to some residents' call bells.
- based on a review of resident dependency levels and care needs

21. Action Required:
Under Regulation 15(1) you are required to: Ensure that the number and skill mix of staff is appropriate to the needs of the residents, assessed in accordance with Regulation 5 and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Staffing will be reviewed to ensure the safety of our residents.
There after staffing will be reviewed on a regular basis depending on the resident's dependency levels.

Proposed Timescale: 31/03/2016

Theme:
Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
While staff were observed to practice safe moving and handling procedures on the days of inspection, all staff had not completed up to date mandatory training in this area.

22. 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:
Remaining staff will be updated in Manual Handling by the end of this year.

Proposed Timescale: 31/12/2015