

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Belmont House Private Nursing Home
Centre ID:	OSV-0000014
Centre address:	Galloping Green, Stillorgan, Co. Dublin.
Telephone number:	01 278 4393
Email address:	info@belmontcare.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Belmont Care Limited
Provider Nominee:	Albert Connaughton
Lead inspector:	Nuala Rafferty
Support inspector(s):	Jim Kee;Shane Walsh
Type of inspection	Announced
Number of residents on the date of inspection:	142
Number of vacancies on the date of inspection:	19

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

The inspection took place over the following dates and times

From:	To:
26 April 2016 08:00	26 April 2016 19:30
27 April 2016 08:00	27 April 2016 18:00

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	Substantially Compliant
Outcome 03: Information for residents	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	Compliant
Outcome 08: Health and Safety and Risk Management	Non Compliant - Moderate
Outcome 09: Medication Management	Non Compliant - Moderate
Outcome 10: Notification of Incidents	Compliant
Outcome 11: Health and Social Care Needs	Non Compliant - Moderate
Outcome 12: Safe and Suitable Premises	Substantially Compliant
Outcome 13: Complaints procedures	Compliant
Outcome 14: End of Life Care	Substantially 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	Compliant
Outcome 18: Suitable Staffing	Non Compliant - Moderate

Summary of findings from this inspection

This was an announced inspection and formed part of the assessment of the application for renewal of registration by the provider. The inspection took place over two days and as part of the inspection, practices were observed and relevant documentation reviewed such as care plans, medical records, accident logs, policies and procedures and staff files. The views of residents, relatives and staff members of

the centre were also sought.

Information in the form of notifications and unsolicited information were also considered as part of the inspection process.

As part of the application for renewal of registration, the provider was requested to submit relevant documentation to the Health Information and Quality Authority (HIQA). All documents submitted by the provider, for the purposes of application to register were found to be satisfactory. The fitness of the nominated person on behalf of the provider were previously determined through a fit person process and both he and the person in charge demonstrated knowledge of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) (the regulations) and the National Quality Standards for Residential Care Settings for Older People in Ireland (the standards) throughout the inspection process.

A small number of residents' and relatives questionnaires were received by the Authority prior to and during the inspection. The opinions expressed through both the questionnaires and in conversations with the inspectors on site were broadly satisfactory with services and facilities provided. In particular, residents were very complimentary on the manner in which staff delivered care to them commenting on their patience, good humour and respectful attitude.

Overall, evidence was found that residents' healthcare needs were met. Residents had access to medical officers and consultant geriatrician services within the centre. Access to allied health professionals such as physiotherapy, speech and language therapists and to community health services were also available. However, improvements were found to be required including level of nursing staff, risk management and the assessment, planning and recording of care.

Unsolicited information received by the Authority raising concerns for the management of sudden collapse and appropriate intervention by staff was reviewed during this inspection. The person in charge had recently conducted a review of staff responses to and practices in emergency care situations and found staff required updated training to improve competency. Measures were in place to improve staff competency including training and spot checks by the management team.

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:

A written statement of purpose was available that broadly described the service provided in the centre and contained all of the information required by Schedule 1 of the Regulations.

Copies of the document were available in the centre

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):

No actions were required from the previous inspection.

Findings:

There was a clearly defined management structure that identified the lines of authority and accountability as outlined in the statement of purpose. The senior management team included the provider, the person in charge, assistant director of nursing (ADON) clinical nurse manager's (CNM's) and household manager.

The systems in place to monitor care included a monthly management team meeting attended by the senior management team.

Inspectors were told that the team discussed quality and safety of care issues such as; staff turnover, recruitment and retention, training premises maintenance and upgrades, equipment requirements, audits conducted and HIQA requirements and inspections. On review of minutes of meetings held during Quarter 1 2016, it was noted that the minutes were brief and analysis of audits and learning or improvements to initiate practice changes were not documented.

The person in charge acknowledged that most of the discussions at both the formal monthly meetings and regular informal meetings between the management team were verbal and not recorded.

A system of audit on aspects of care both clinical and non clinical was in place. Audits were in progress for 2016 including; medication management; slips/trips and falls; restraint and nutrition; cardiac pulmonary resuscitation and use of automatic external defibrillator device; safety and security and dementia care.

These audits assessed the knowledge of staff on the policies and procedures in place to guide practice and the competence of staff to implement those procedures. Audits were conducted using a variety of approaches such as analysis of incident reports, data collation and spot checks on units. But it was noted that overall the audits were not detailed enough or broad enough to identify trends or current or future risks or where these may occur. Evidence of this is detailed under other outcomes including Outcomes 5, 9, 11 & 18 where the audits were not fully effective in monitoring practices in medication administration times; supervision of personal care; cleaning of equipment and assessing planning or recording of care.

Most of the audits viewed included some learning and actions required to improve practice although they did not always include the actions taken to address the problem identified, when the action was implemented or reviewed to determine effectiveness. But evidence that audit outcomes formed part of decision making rationales on reviews of staffing resources was not found. This is further referenced in Outcome 18

An annual review of the safety and quality of care was conducted and a report on the review was available. The report was detailed and identified the key performance indicators such as; occupancy; staff recruitment, retention and training; complaints analysis and results of resident satisfaction surveys. Other quality care indicators were referenced to establish the standard of and safety and quality of service being delivered including; reduction in use of restraint; reduction or prevention of falls; improvements in general care and premises developments and upgrades.

Judgment:

Substantially Compliant

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

<p>Outstanding requirement(s) from previous inspection(s): The action(s) required from the previous inspection were satisfactorily implemented.</p> <p>Findings: Each resident had an agreed written contract which deals with the resident's care and welfare. The contract included all details of the services to be provided for that resident and the fees to be charged. This included a list of facilities and services provided including laundry, meals, and housekeeping. Services offered in the centre which incurred additional fees were listed. A guide to the centre was available to residents and relatives. This described the centre services, management, complaints procedure, and contact information for useful external bodies. Communal areas such as the lobby also had information on display regarding the complaints procedure, evacuation instructions, details of staff on duty and contact details' for advocacy services.</p>
<p>Judgment: Compliant</p>

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 centre was managed by a suitably qualified and experienced nurse. The person in charge held authority, accountability and responsibility for the provision of the service.

Through the Authority's fit person process it was noted that there was daily engagement in the governance, operational management and administration of the centre. The person in charge facilitated the inspection process by providing documents and having good knowledge of residents' care and conditions and also had the qualifications and experience required by the legislation.

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):

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

Findings:

Records set out in Part 6 of the Regulations were available and kept in a secure place. The Statement of Purpose and Residents' Guide was complete and available. A copy of the insurance cover in place was provided which meets the requirements of the Regulation. Overall, general records as required under Schedule 4 of the Regulations were maintained including key records such as appropriate staff rosters, accident and incidents, nursing and medical records and operational policies and procedures as required by Schedule 5 of the Regulations. Planned rosters were in place in all units and an actual working rota was maintained electronically. A final version was also printed and retained.

In a sample of staff files reviewed, most contained the requirements listed in Schedule 2 of the regulations, but two files did not contain evidence that the staff had been vetted by the Garda Síochána. Inspectors acknowledge that changes to processes in the National Vetting office are contributing to this delay at the time of inspection.

All records required under Schedule 3 of the Regulations were maintained in the centre. But improvements were required in respect of ensuring timely recording of the delivery of care so that the content of these records were accurate and reliable. The full implementation of care plans and the recommendations of consultants, GP's and other health professionals are reliant on the accuracy and timely recording of care interventions such as monitoring of food and fluid intake and output; repositioning; exercise regimes; sleep patterns and changes in mood or behaviour. It was found that for the majority of residents the care delivered was not recorded until late in the afternoon when all of the care delivered was inputted into the record at the same time. For example, where residents require food or fluid intake and output monitoring or repositioning every two hours. The accuracy of the information being recorded was questionable where staff would have provided assistance to several residents during the day and have to remember exactly the level of detailed care and assistance provided. As the nurses or CNM's had not supervised the care interventions, or reviewed the adequacy of recording of the care, it could not be determined that the care plan had been fully implemented.

These findings are also referenced under Outcome 18

The importance of the accuracy of this information as it relates to the implementation

and effectiveness of care plans was discussed with managers and the person in charge.

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:

Suitable arrangements were in place for periods of absence of the person in charge and the provider complied with his responsibilities to notify the Authority when a change occurred to both the person in charge and the nominated person to replace them. The fitness of the assistant director's of nursing to replace the person in charge in the event of her absence was determined through observation and discussion during the inspection and had the qualifications and experience required by the legislation.

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):

Findings:

A review of the use of restraint found that there was a reduction in the use of bed rails throughout the centre although bed rails were still in place for some residents. The use of bed rails and lap belts was reduced. A culture of promoting a restraint free environment with an increase in the use of alternative safety measures such as bed alarms, roll out mats and low-low beds was being established.

Some evidence of alternatives considered or trialled was available although this was not always included or referenced in the assessments or in associated care plans. This is further referenced under Outcome 11.

Staff had received training on the prevention of elder abuse and all staff spoken too were clear on their role and responsibilities in relation to reporting abuse. Staff were also knowledgeable in recognising the possible signs and symptoms, responding to and managing abuse.

Procedures to protect residents, such as a robust recruitment system, staff induction and training were also in place and implemented.

In conversations with them, inspectors were told by residents that they felt safe and secure in the centre and relatives also confirmed that they did not have any concerns for the safety of their loved ones.

Inspectors were told by the provider nominee and person in charge that they were not involved in assisting the management of financial affairs for any of their residents.

The management of risks associated with negative peer interactions and concerns in relation to unmet needs raised by relatives were reviewed during the inspection. A number of these were brought to the Authority's attention through the notification process by the person in charge throughout quarter four of 2015 and the first quarter of 2016. It was found that the person in charge had appropriately conducted and completed preliminary investigations into the more significant incidents.

Judgment:

Compliant

Outcome 08: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Safe care and support

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

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

Findings:

Emergency lighting and fire fighting equipment, directional signage and appropriate fire procedures were available throughout the building.

The internal and external premises and grounds of the centre appeared safe and secure, with appropriate locks installed on all exterior doors and a register of visitors was available. A CCTV system was in place both internally on corridors and externally.

The centre was found to be visibly clean and clutter free.

Completed logs were maintained on daily, weekly, monthly and quarterly tests and checks of fire equipment, doors, exit routes and emergency lighting. Certification of testing and servicing of extinguishers, fire retardant materials and the alarm system were documented. The building's fire and smoke containment and detection measures

were appropriate to the layout of the building and exits were free of obstruction. There was a policy around responding to emergency and evacuating the centre that identified the location of temporary accommodation for residents. All residents had personal emergency egress plans (PEEPs) which identified the cognitive understanding, level of mobility and evacuation notes of each resident. These plans were printed on colour coded tags and placed on the end of each bed for ease of reference by staff.

All staff had received training in fire safety within the past 12 months and were familiar with what actions to take in the event of a fire alarm activation. Inspectors were told regular fire drills were held which included activation of the fire alarm, one staff person on each floor responded by going to the reception desk on the ground floor and checking the fire panel. The nurse on the first floor was the identified person in charge of response to the fire alarm and all staff knew this. Records of fire training listed the dates of drills and the staff present, though no details were recorded on the time of day, the time taken to complete, or the observations and learning taken from the drill. All staff were familiar with the principles of horizontal evacuation but inspectors were told that although simulated fire drills were held annually during formal training, practiced fire drills that included simulation of an actual evacuation to determine the competency of staff to use evacuation equipment such as evacuation sheets, or the principles of vertical evacuation did not take place.

Appropriate arrangements for investigating and learning from serious incidents/adverse events which identified residents who were at risk of falls and put in place appropriate measures to minimise and manage the risks was in place. There were arrangements in place to review accidents and incidents within the centre, and residents who had fallen had falls risk assessments completed after the falls and care plans were updated. The review of falls included a full post fall assessment by both nursing team and the physiotherapist. Inspectors noted that residents who fell and sustained fractures normally associated with ongoing reduction in mobility and general deterioration in well being had good post fall outcomes. Evidence was found that this was due to regular review by the physiotherapy team with timely implementation of recommendations and monitoring by the nursing team.

A risk register was established which was regularly reviewed and updated. Governance and supervision systems were in place to monitor residents at risk of falls, wandering or negative interactions. These were reviewed on an ongoing basis.

Inspectors observed that staff implemented the principles of current moving & handling guidance when assisting residents to transfer.

Systems to support staff knowledge and implementation of best practice to ensure good infection prevention and control were in place. But these systems did not clarify the roles of the cleaning and healthcare staff in relation to the cleaning of some items of equipment. As a result equipment regularly used by residents were not being maintained in an hygienic state such as; crash mats; raised toilet seats and hoists in between use.

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):

Findings:

Inspectors found that there were written operational policies in place in the centre relating to the ordering, prescribing, storage, and administration of medicines to residents.

Medicines were supplied to the centre by a retail pharmacy business in a monitored dosage system that consisted of blister packed medication. Medicines were stored securely in the centre in medication trolleys or within locked storage cupboards. A secure fridge was available to store all medicines and prescribed nutritional supplements that required refrigeration, and temperatures were checked and recorded on a daily basis. Controlled drugs were stored securely within a locked metal cabinet, and balances of all controlled drugs were recorded in the controlled drugs register. Nursing staff checked and documented the balances of all controlled drugs twice daily at the change of shift. Nursing staff were familiar with the procedure for disposing of unused or out of date medicines.

Inspectors observed nursing staff administering medicines to residents during the evening administration rounds on one of the units. The nurse knew the residents well, and was familiar with the residents' individual medication requirements. Inspectors observed that the nurses took time to ensure each resident was comfortable before administering their prescribed medicines in a person centred manner. However, the duration of the administration of morning medication was found to be outside of the timeframes recommended for administration for medications prescribed to residents at specific times. For example, medications which were prescribed for administration at 9 am were not being administered until up to 2 hours later. One nurse was rostered on each floor and it was observed on some floors that nurse's were regularly interrupted to respond to call bells or deal with clinical queries.

Medication audits were conducted in the centre and these audits included input from the external pharmacist, general practitioner and nursing team. These audits covered some aspects of medication management practices such as; storage, labelling, administration and prescription records, controlled medicines and temperature controls on medicine refrigeration.

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
<p>Outstanding requirement(s) from previous inspection(s): No actions were required from the previous inspection.</p> <p>Findings: A record of all incidents occurring in the designated centre was maintained and, where required, notified to the Chief Inspector.</p>
<p>Judgment: Compliant</p>

<p><i>Outcome 11: Health and Social Care Needs</i> <i>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.</i></p>
<p>Theme: Effective care and support</p>
<p>Outstanding requirement(s) from previous inspection(s): Some action(s) required from the previous inspection were not satisfactorily implemented.</p> <p>Findings: Residents had good access to GP and consultant geriatrician services. Regular reviews of residents overall health was found on admission, readmission following return from acute hospital care and as required when clinical deterioration was noted. There was evidence of access to specialist and allied health care services to meet the care needs of residents such as opticians, dentists and chiropody services. Access to palliative care specialists, dietician, physiotherapy and speech and language were also available. Transfer of information within and between the centre and other healthcare providers was found to be good. Discharge letters for those who had spent time in acute hospital and letters from consultants detailing findings after clinic appointments were seen</p> <p>The arrangements to meet residents' assessed needs were set out in individual care plans and each resident had some care plans completed, but care plans were not found to be in place for every identified need. Although for the majority of residents, healthcare needs were met, several key areas for improvement were required in the documentation of care given.</p> <p>Inspectors found that improvements were required to deliver a safe and suitable standard of care and to ensure the clinical care needs of all residents were fully met.</p>

A number of core risk assessment tools to evaluate levels of risk for deterioration were completed but comprehensive assessments were not fully completed for every identified need. These included cognitive impairment and capacity for decision making assessments, pain assessments and restraint assessments.

A strong system to make sure healthcare plans reflected the care delivered and were amended in response to changes in residents' health was not in place. These plans were not being checked to make sure they were detailed enough to maintain or improve a resident's health. The daily nursing progress notes did not always refer to changes in health care plans or changes to treatments or recommendations made by clinicians to give a clear and accurate picture of residents' overall health.

Where care plans were in place they were not specific enough to guide staff and manage the needs identified examples included;

-Positive behaviour support plans were in place to manage behaviours associated with restlessness and agitation. But these did not fully guide staff on the signs to look for as potential triggers to responsive behaviour. These plans also did not guide staff on the type of distraction techniques which could be employed to reduce escalation or of all measures which were known to manage the behaviour and prevent recurrence.

Documentation available and viewed did not give an accurate and full picture of the effectiveness of measures used to manage behaviours to inform future care planning and improve the residents overall health and well being.

-Medications used on an as required basis (p.r.n.) to manage the behaviours were not referenced in the care plans and a separate care plan for medication management was not in place. It was noted that for some residents a number of different p.r.n. medications were prescribed.

-Risk Assessments and care plans in place were not linked and in some instances were contradictory. This posed risks for resident's safety and the overall consistency and management of care needs. Although as previously mentioned in Outcome 7, the use of bed rails and lap belts was reduced and a culture of promoting a restraint free environment was being established, bed rails were still in place for some residents without a clear rationale for the decision. It was noted that some residents had bed rails in place and these were being used in conjunction with alternative safety measures such as bed alarms or roll out mats. The use of the bed rails making the alternative measures redundant. It was also found that risk assessments in place and reviews of those assessments did not reference where residents had previously fallen or climbed over the bed rails and were at risk of injury.

Overall it was found that evaluations of care plans together with nursing progress notes and other supporting documentation to evidence the delivery of a high standard of care were not appropriately linked to give a clear and accurate picture of residents' overall health management.

Judgment:

Non Compliant - Moderate

Outcome 12: Safe and Suitable Premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents' individual and collective needs in a comfortable and homely way. The premises, having regard to the needs of the residents,

conform to the matters set out in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The centre although not purpose built has been extensively renovated and extended to provide a comfortable spacious and modern living facility whilst still retaining many of the charming and elegant features of the original building.

Belmont House has six floors. Resident accommodation is located on all floors with the exception of the ground floor. The centre consisted of; 81 single bedrooms 4 twin and 1 triple bedroom on this visit. There were appropriate communal spaces, private areas, and storage available.

The premises were fully reviewed at the last registration inspection. Inspectors were told that some internal structural changes have taken place since then. This was fully discussed with the provider and changes made were outlined on a word document. Floor plans had been submitted previously. Evidence that the changes complied with the fire and planning bye laws were viewed.

Overall it was found that adequate private and communal space was provided and the design, layout and decor of the centre provided a comfortable and tastefully furnished environment for residents with small areas of diversion and interest.

Residents' bedrooms were personalised with pictures photographs and home furnishings. Call bells were available in resident's bedrooms and communal rooms, grab rails and safe flooring facilitated safe mobilising and the centre was comfortably warm.

The maintenance both internal and external was of a good overall standard. Maintenance staff were observed on site at the centre. They attended to daily reports from staff and upkeep of the premises.

Although adequate storage was available in the centre it was found that items of equipment such as pressure relieving cushions and incontinence wear was stored in some residents bedrooms, this required to be reviewed.

Assistive equipment was in place and available for use and in good working order, service records were up to date and maintenance contracts were in place.

All bedrooms were of sufficient size and layout for the residents, appropriately decorated and with adequate storage for belongings including lockable space for valuables. Privacy screening was in place in twin and triple rooms. All bedrooms had ensuite bathrooms. The centre as a whole was of a suitable layout and design for the residents and was of sound construction and in a good state of repair. A lift was available centrally for moving between floors. Facilities also included; a hair salon, oratory space and arts and crafts room. There was dining space on each floor of suitable size for the number of residents.

There were multiple living rooms and seating space in foyers, with adequate private space in which residents could receive visitors.

The purpose and function of each room was identified with a few exceptions which the inspector was assured would be rectified. Appropriate signage and cueing to support freedom of movement for residents with dementia was also found. Picture cueing on bedrooms, bathrooms and toilet areas were in place. Colour cueing was also used with deep colours on bathroom/toilet doors

There was a well maintained and secured external garden on the ground floor. The garden was nicely decorated and free of hazards. The area was fenced and secure from unauthorised entry. Staff advised that the area is used for outdoor activities such as barbeques in the summer months.

On review of the sluicing facilities it was noted that these needed to be reviewed to ensure that the household staff did not have to travel to other floors to empty their mop buckets following cleaning. It was noted there were no sluice sinks available on the fifth and third floors. This was identified to the provider.

It was also noted that some radiators were hot. This was raised during the inspection and the temperature reduced, however regular checks of radiators' temperature is required to ensure resident safety.

Judgment:
Substantially Compliant

Outcome 13: Complaints procedures
The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:
Person-centred care and support

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

Findings:
Policies and procedures which comply with legislative requirements were in place for the management of complaints. Residents were aware of the process which was displayed.

On review of the record of complaints there was evidence that all complaints were documented, investigated and outcomes recorded. Complainants were notified of the outcomes and a review was conducted to ascertain the satisfaction of the complainant further to issues being resolved.

Judgment:
Compliant

Outcome 14: End of Life Care

Each resident receives care at the end of his/her life which meets his/her physical, emotional, social and spiritual needs and respects his/her dignity and autonomy.

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

A small number of residents were receiving 'end of life' or 'comfort care' during this inspection. A sample of documentation reviewed found that there were arrangements in place for capturing residents' end-of-life preferences in relation to issues such as; spiritual needs or preferences for place of death or funeral arrangements. It was noted that residents family and friends could be facilitated and religious and cultural preferences respected as far as practicable. Access to specialist palliative care services were available where appropriate.

But improvements related to the determination of resident's capacity to understand complex issues and make informed decisions were required.

The legal status of residents with dementia or cognitive impairments was not always established prior to or since admission. Assessment of capacity for all residents with a formal or suspected diagnosis of dementia or other cognitive impairment was not conducted.

Not for resuscitation forms were in place for a number of residents. Where these were in place they were signed by the resident's family and general practitioner. But it was noted that the forms were not always signed on the same day and evidence of discussions on the type or level of healthcare interventions to be implemented was not found. The not for resuscitation forms identified that no actions would be taken in the event of a sudden collapse to restart heart function or breathing. The form also states that this did not preclude the provision of other emergency care, prior to death. But clarification on the extent or level of these emergency interventions was not outlined. Evidence of the resident's involvement in relation to their will and preference in these decisions was not found.

This was discussed in full with the management team prior to the close of inspection.

The difficulties staff face in assessing capacity and the degree of sensitivity is acknowledged by inspectors who advised the team that their practice should be reflective of the Assisted Decision making Capacity Act 2015 due to be enacted.

Judgment:

Substantially 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:

Residents were provided with food and drink at times and in quantities adequate for their needs. Assistance was observed and was offered to residents in a discreet, patient and sensitive manner by all staff.

The dining experience was conducive to conversation. Those residents on modified diets were offered the same choices as people receiving normal diets. A rolling menu was in place to offer a variety of meals to residents.

Most residents took their meals in the dining rooms located on each floor in the centre and tables were appropriately set with cutlery condiments and napkins. Residents spoken with all agreed that the food provided was always tasty hot and appetising. Food was served from a hot plate by a team of staff and was well presented. Modified consistency diets were served appropriately with each element of the meal presented in separate portions on the plate. A list of all special diets required by residents was compiled on foot of the individual residents' reviews and copies were displayed in the main kitchen and in the kitchenettes on each unit.

Drinks such as water, milk, tea and coffee were available. Access to fresh drinking water at all times was available, jugs of water were observed in residents' rooms and water dispensers were available.

Evidence of referral to relevant allied health professional including dietician or speech and language therapists was found and there was a system in place to monitor the intake of residents identified as at risk of malnutrition although inspectors were told no residents were identified as requiring same at the time of inspection.

Judgment:

Compliant

Outcome 16: Residents' Rights, Dignity and Consultation

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

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that the residents were consulted on how the centre is run. Residents' meetings were held once a month. Issues that were raised in these meetings were documented and submitted to the person in charge. Each meeting received an official response from the Person in Charge which was read out at the following meeting. Often the suggested changes were implemented and when this was not possible explanations were provided to the residents.

Residents had access to advocacy. Four activity coordinators were the nominated advocates for the residents and also facilitated the monthly residents' meetings. Contact information for external advocate groups was on display in the centre.

There were no limitations on residents receiving visitors in the centre and facilities were available for residents to receive visitors in private.

Throughout the inspection the staff were observed by inspectors to be courteous towards the residents and treated residents in a respectful and dignified way.

All residents had access to television, radio, newspapers and a private telephone.

Activities were organised by four activities coordinators. Weekly activities were planned for the various areas of the centre. These differed each week as they were based on various themes, for example nature, humour and love. Each resident was assessed every four months to determine their ability/desire to participate in various activities. Records were kept of each residents' participation in activities and this was used to assist in planning the weekly activities for the centre. However there was a lack of evidence to suggest that each resident was provided with equal opportunity to participate in the activities. Inspectors noted that some residents had not attended an activity in over three weeks. It was pointed out by staff that the residents may not have been interested in the activities, but there was no record of this nor provision of alternative one to one activities for these residents. Staff confirmed that residents who remained in their room or did not wish to take part in group activities were not provided with alternative options based on their needs, interests or capacity.

The centre assisted residents to maintain links with the local community. The centre owned a mini bus and took residents on day trips to amenities both local and in the greater Dublin area approximately once every two weeks.

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:

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

A policy on residents' personal property was in place and implemented using an inventory on clothes and valuables belonging to residents upon admission. In a sample of those reviewed these were updated.

All clothing was labelled for the laundry and new clothes were added to an initial list by staff.

Adequate space was provided for residents' personal possessions and it was noted that clothing was stored in a neat and appropriate manner.

Judgment:

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 review of the number and skill mix of staff was found to be required to ensure that a safe and suitable standard of care was delivered to the current resident profile.

The staff rota was checked and found to be maintained with all staff that worked in the centre identified.

Systems were in place to provide relief cover for planned and unplanned leave. Actual and planned rosters were in place.. It was noted that a bank of relief staff was in place to maintain consistency of care.

A specific staff allocation system was in place that identified the staff for each area on every floor in the centre. All staff were aware of the system which was implemented in full. The system also identified staff supervision of communal areas throughout the day. But improvements were required to the level of supervision to ensure care was delivered and recorded in a timely and responsive manner.

On observation and in conversation with staff it was noted that supervision of practice to ensure care was delivered appropriately and responsively in a manner that ensured care

plans were fully implemented was limited. This is previously referenced in full under Outcome 5.

The resident profile was frail older persons with a high level of complex needs. The current resident population age were between 65 and 96 years old with the majority assessed as being at high/ maximum dependency, meaning that they required the assistance of two staff with most or all of the activities of daily living. In addition the centre provides short term convalescence to persons recovering from recent surgery or debilitating illness.

The ratio of direct care nursing staff to residents was 1;24 on both day and night shift- this did not include the ADON or PIC who do not provide direct care. Where the CNM's are included for day time (although they do not provide full time direct care) it is 1;18 This ratio.

The ratio of direct healthcare assistant to resident for day shift was 1;5- this included two twilight or evening shifts. The night time ratio was 1;20.

The ratio of overall direct care staff to resident ratio on days were 1:4(including both CNM and twilight shifts) and 1:11on nights which would meet current recommended staffing guidance for overall staffing but not for qualified professional nursing staff levels.

The lack of skilled and experienced nursing numbers contributed significantly to findings on inspection previously referenced under Outcomes 7;8;9;11 in that; Nurses were unable to monitor and supervise the standard of direct care practices to ensure care plans were fully implemented.

Regular interruptions during administration meant that medications were administered outside recommended timeframes

lack of supervision of practice related to timely delivery and recording of care; cleaning of equipment such as toilet seat raisers and crash mats

Limited time to comprehensively review assessments. Care planning evaluation and monitoring were not meeting professional guidance

A lack of built in capacity at night to meet unforeseen circumstances with only two staff on each floor with the exception of the high dependency unit which had three.

Managerial and clinical oversight to provide guidance and direction to staff or to manage emergency or other unforeseen event was limited. One of the nurses rostered at night was nominated as a 'supervisor' but this person also continued to have a full role and responsibility to deliver direct nursing care to the residents on their unit.

These findings replicate some of the findings of the last inspection.

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:

Nuala Rafferty
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority Regulation Directorate

Action Plan



Provider's response to inspection report¹

Centre name:	Belmont House Private Nursing Home
Centre ID:	OSV-0000014
Date of inspection:	26/04/2016
Date of response:	24/06/2016

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:

Governance systems in place were not fully effective in monitoring practices and cultures found such as medication administration times; supervision of personal care; cleaning of equipment and assessing planning or recording of care.

1. Action Required:

Under Regulation 23(c) you are required to: Put in place management systems to

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

ensure that the service provided is safe, appropriate, consistent and effectively monitored.

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

Since our inspection the management team have had a number of meetings to discuss the findings of our inspection and to plan how to improve our supervision and auditing of the floors effectively for both day and night dutys. We have created a CNM audit folder for each floor. The CNM responsible for the floors has a serious of items which we noted from the inspection findings and the CNM will audit and sign off on the items at various timeframes agreed by the management team. We feel that this folder will provide evidence of audit, supervision and corrective action of the items identified during the inspection.

Medication Management:

With regard to the administration of medicines, it is not normal practice that the administration of medicines goes over the acceptable time frame. During the inspection this was observed to have happened on the 2nd day only and with one of the six staff nurses that were on duty. However on the day in question this staff nurse was a relatively new nurse and it was her first experience of a HIQA inspection. She was nervous and she did leave her medication round to answer bells. Under normal circumstances we do not even put phone calls through to the nurses during the medication round. Nurses wear the red medication bibs to alert people that they are not to be disturbed during the administration of medications.

Nurses do not normally answer bells during the medication rounds and are normally only disturbed if it is absolutely necessary.

Since our inspection we have been auditing the medication rounds closely and medications are being administered within acceptable timeframes. This is something we will continue to audit so as to ensure medicines continue to be administered within the acceptable recommended guidance for medication efficacy.

Supervision & Personal Care:

Where resident's require regular monitoring such as food or fluid intake and output monitoring or repositioning two hourly, this is then documented in a timely manner after the resident has been attended to. During the inspection it was observed that a resident did have their pressure areas relieved but it was documented at a later period. In Belmont House we usually document pressure relief contemporaneously however during our two day inspection staff time was at times taken up with speaking with the inspectors and this did have an impact on staff's usual working routine. All staff are aware that documentation should be recorded promptly after a resident is attended to. A staff meeting has taken place on all floors since our inspection to discuss this and pressure relief charts and other such monitoring charts are being checked by both the staff nurses on the floors along with the CNM's, ADON and DON on a daily basis.

Cleaning of Equipment:

A new cleaning schedule has been implemented on all floors. It clearly states the items to be cleaned by whom and when. This was implemented immediately and is being checked by the care supervisors and nurses on the floors along with the CNM and ADON for each of the floors. Please see a copy of the forms attached.

Assess, Planning or Recording of Care:

A review of our care plans is taking place so as to ensure that our risk assessments directly link to the formation and maintenance of our care plans. This process is taking place on all floors and will be completed by the end of July. This review is in conjunction with ongoing in-house care plan training and additional care plan training by an external trainer that is being organised for staff nurses in July. The practice development nurse from NHI is also coming to review, audit and advise the nursing staff on care planning. This is taking place on the 23rd of June. This is further discussed under Outcome 11.

Proposed Timescale: 31/07/2016

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 record of Garda vetting was not available on two of the staff files that were reviewed.

2. Action Required:

Under Regulation 21(2) you are required to: Retain the records set out in Schedule 2 for a period of not less than 7 years after the staff member has ceased to be employed in the designated centre.

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

Belmont House applies for Garda Clearance through Nursing Homes Ireland. On the 23rd of March we received the attached email from NHI. It was to inform us that there was a new act coming out with regards to applying for Garda Clearance and that the last date to submit the old Garda Clearance Forms was the 30th of March. The new act came into force on the 29th of April. One of the staff files examined showed a record that Garda Clearance had been sent, however we have not received back the clearance for this staff member yet as the process has slowed down due to the commencement of the new Act. This is something that is out of Belmont Houses control. The second staff member did not commence employment until April 2016, so therefore we were unable to apply for Garda Clearance for this person as we were waiting on the new Garda Vetting Process to commence. I had been in touch with NHI many times regarding the new application process and my last call was on the 2nd of June and it is hoped that we will be able to apply for Garda Clearance in the next week or so. Since the inspection we are now asking staff awaiting Garda Clearance to sign a self declaration form stating that they have no criminal convictions. Belmont House takes the vetting and selection of staff very seriously and always applies for Garda Clearance for all staff employed here. Unfortunately this situation was out of our control. The new Garda Vetting system has now commenced and all applications have been sent.

Proposed Timescale: 24/06/2016

Theme:

Governance, Leadership and Management

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

The delivery of care was not recorded in a timely manner and was not sufficiently accurate to determine that the care plans in place were appropriately and fully implemented.

3. 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:

Where resident's require regular monitoring such as food or fluid intake and output monitoring or repositioning two hourly, this is then documented in a timely manner after the resident has been attended to. During the inspection it was observed that a resident did have their pressure areas relieved but it was documented at a later period. In Belmont House we usually document pressure relief contemporaneously however during our two day inspection staff time was at times taken up with speaking with the inspectors and this did have an impact on staff's usual working routine. All staff are aware that documentation should be recorded promptly after a resident is attended to. A staff meeting has taken place on all floors since our inspection to discuss this and pressure relief charts and other such monitoring charts are being checked by both the staff nurses on the floors along with the CNM's, ADON and DON on a daily basis.

Proposed Timescale: 24/06/2016

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:

Appropriate infection and prevention control was not being implemented or monitored to ensure all equipment was adequately and appropriately cleaned on a regular basis and prior to re use by residents.

4. 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 new cleaning schedule has been implemented on all floors. It clearly states the items to be cleaned by whom and when. This was implemented immediately and is being checked by the care supervisors and nurses on the floors along with the CNM and

ADON for each of the floors. Please see a copy of the forms attached.

Proposed Timescale: 20/05/2016

Theme:

Safe care and support

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

Systems in place did not ensure staff were fully familiar and competent in all aspects of the procedures to be followed in the event of a fire. Fire drills practiced by staff did not include all of the procedures to be followed including use of evacuation equipment such as evacuation sheets, or the principles of vertical evacuation.

5. 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:

In Belmont House we carry out fire drills monthly. This usually involves the practice of Progressive Horizontal Evacuation. Once a year we have an outside fire safety company that comes in and staff get to practice using fire extinguishers and ski sheets along with a theoretical session on fire safety in nursing homes. In the past we had been advised that our fire drills should be announced. The system of Progressive Horizontal Evacuation has been agreed with the local fire officer. Both Dun Laoghaire Fire Station Personnel and Donnybrook Fire Station Personnel have visited our site and have copies of our floor plans and have practiced response times to this facility. Our fire alarm system is a fully addressable system and fire station personnel were satisfied with our systems on their last inspection.

Since our inspection we have had 2 unannounced fire drills, one with the day staff and one with the night staff. During this a mock fire was staged in a room and staff practiced putting out the fire, getting the correct fire extinguisher and using the ski sheets to evacuate a staff member off the bed, down the corridor and down the stairs. These fire drills were audited as they happened and any learning or areas identified for improvement along with good practice is discussed at management level and conveyed back to staff.

The practice going forward will be to continue with unannounced fire drills with a mock fire on a different floor each month. This will involve both day and night staff and should help to improve staff competency in the practicalities of Progressive Horizontal Evacuation.

Proposed Timescale: 16/06/2016

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:

Prescribed medicines were being administered outside the prescribed timeframe due to the length of time taken to complete medication administration rounds.

6. 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:

In Belmont House we take the administration of Medications very seriously.

It is not a usual occurrence that our medication rounds go over the acceptable timeframes for the administration of medication. However, during our inspection one of the staff nurses went over the acceptable timeframe for administering medications on one of the days. This staff nurse is a relatively new member of staff, this was her first experience of a HIQA inspection and she was nervous. She did answer bells during her medication round. However, this is not usual practice as nurses concentrate on the medication round and care staff answer bells during this time.

Our staff nurses wear red medication administration bibs during the medication rounds to remind people not to disturb them. Staff Nurses are not disturbed during medication administration except in exceptional circumstances. We have been auditing our medication administration time frames since our inspection to ensure that medicines are administered within recommended guidance for medication efficacy. These audits are showing that medicines are being administered within acceptable time frames.

We continue to audit and observe the administration of medications and at present we are satisfied that we are operating within the acceptable timeframes. Our CNM's and ADON continue to monitor and audit the administration of medicines for day and night duty to ensure that we continue to comply with the recommended guidance for medication efficacy.

Proposed Timescale: 12/05/2016

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:

Assessment and care planning were not specific enough to direct the care to be delivered or guide staff on the appropriate use of interventions to consistently manage the identified need.

Complete comprehensive nursing assessments were not carried out for each resident.

7. Action Required:

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

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

Consistency in care planning can be a challenge to achieve especially with the current movement of so many experienced nursing staff from private facilities to public facilities. We have managed to maintain regular stable staffing on all floors and our care plans are all currently being reviewed and updated to ensure consistency in assessments and the creation of care plans which reflect the resident's needs. Care plans are reviewed regularly by our CNMs, ADON and DON. Any inconsistencies noted are discussed with all staff nurses to encourage ongoing improvement.

Additional care plan training by an external trainer is also being organised for nursing staff which is due to take place in July.

Proposed Timescale: 31/07/2016

Theme:

Effective care and support

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

Reviews of care plans did not include a determination of the effectiveness of the plans to manage the needs identified.

8. Action Required:

Under Regulation 05(4) you are required to: Formally review, at intervals not exceeding 4 months, the care plan prepared under Regulation 5 (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.

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

Belmont House has recently started using a new computerised care system for our residents. Migrating the information from the old computerised system to the new system and ironing out the associated teething problems is now complete and staff competency with the new system has improved considerably.

As part of our care plan reviews that are taking place at present we are also reviewing our care plan evaluations and they are being updated along with the care plans.

Additional care planning training is also being organised for staff which is due to take place in July.

Proposed Timescale: 31/07/2016

Theme:

Effective care and support

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

Residents' capacity was not assessed or reviewed to determine their ability to give consent to level of care interventions at end of life stage prior to decisions being made on their behalf.

9. Action Required:

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

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

Resident's capacity is assessed and where necessary residents are referred to Medicine for the Elderly and or the Psychiatry of Old Age. It has been acknowledged in Outcome 11 "that residents have good access to consultant geriatric services". All residents have an Abbreviated Mental Test Score (AMTS) carried out 3 monthly. When end of life decisions are being made it is discussed with the resident, where the resident is capable of having this discussion, the resident's next of kin and the resident's GP.

Where a resident is unable to convey their end of life wishes we liaise with the resident's next of kin as they know the resident best and we document any wishes that the resident may have. A discussion takes place with the GP and the resident and family and then the end of life wishes are documented.

Belmont House is aware of the new Capacity Bill 2016 and the person in charge has been to two education sessions on the new bill. The PIC is also on the national nursing committee in NHI. However the advice to date regarding this bill is that the system is not in place to carry out the capacity assessments on residents yet and we are waiting for further guidance on how exactly the system will work. It is acknowledged that resident's capacity can change and this is taken into account when residents end of life wishes are being reviewed. This will be documented on our DNR forms going forward.

We have also made contact with trainers in the "Let Me Decide" workshops and we hope this will take place in the last quarter of 2016.

Proposed Timescale: 10/06/2016 Further changes will be necessary as more information is made available regarding the new capacity bill.

Proposed Timescale: 10/06/2016

Theme:

Effective care and support

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

The documentation of care was not sufficiently accurate or appropriately linked to ensure that a high standard of evidence based nursing care was being provided or give a clear and accurate picture of residents' overall health management.

10. 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:

A review of our care plans is taking place so as to ensure that our risk assessments directly link to the formation and maintenance of our care plans. This process is taking place on all floors and will be completed by the end of July. This review is in conjunction with ongoing in-house care plan training and additional care plan training by an external trainer that is being organised for staff nurses in July. A practice development nurse is also coming to review, audit and advise the nursing staff on care planning. This is taking place on the 23rd of June.

Proposed Timescale: 31/07/2016

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:

Improvements to sluicing facilities to ensure the principles of Infection prevention and control are maintained were required.

11. 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:

A sluicing sink will be placed on the 3rd floor and 5th floor.

Proposed Timescale: 30/06/2016

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:

Not all residents in the centre were provided with opportunities to participate in activities in accordance with their interests and capacities in particular those who were frail did not enjoy group activities or spent a lot of time in their bedroom.

12. 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:

A meeting was held with the activity co-ordinator, one of the activity providers, the PIC and one of the administrators and it has been agreed that suitable materials will be provided to these residents to cater for their interest and capacities on a regular basis.

Proposed Timescale: 17/06/2016

Outcome 18: Suitable Staffing

Theme:

Workforce

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

A review of the numbers and skill mix of staff is required to ensure the delivery of safe, suitable and sufficient care to residents' was not in place at all times

13. 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:

A review of the numbers and skill mix of staff is undertaken at least once a month by senior management. However, it was noted during the inspection that these reviews are not always documented in particular where the review does not bring about any change to the numbers or skill mix. The review of staffing involves speaking with staff and the management team with regard to the layout and dependency level of the floors and the skill mix provided. In future these reviews will be documented even where there is no change.

Our most recent review shows that we are providing an average of 3.66 direct care hours per resident per day in our main house and an average of 4.32 direct care hours per resident per day in our high dependency unit. We have reduced our convalescent

beds to five which in turn reduces the turnover of beds.

It has been decided to replace the part time weekend nurse supervisor role with a full time Clinical Nurse Manager post. This will increase our management team and level of supervision throughout the home. Increasing CNM from two to three commencing 31 July 2016. The new post will be on day duty and the ADON and three CNM's will work a seven day roster providing cover during both the week and weekend. Increased cover on each day by the management team from 8am to 6pm. We have also added a new care supervisor role in the Maple Unit.

Night duty care delivery is supervised by the night Staff Nurses on duty and an identified night Nurse Supervisor. This is monitored and audited by periodical management inspection and regular meetings with the night Staff nurses and the night Staff Nurse Supervisors.

Admissions to the home are only scheduled between Monday and Friday and there is only one admission per day scheduled for any one floor including our small convalescent unit on the fifth floor.

Proposed Timescale: 31/07/2016