

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Fairfield Nursing Home
Centre ID:	OSV-0000227
Centre address:	Quarry Road, Drimoleague, Cork.
Telephone number:	028 31 881
Email address:	fairfielddrimoleague@eircom.net
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Fairfield Nursing Home Limited
Provider Nominee:	Seán Collins
Lead inspector:	John Greaney
Support inspector(s):	Mairead Harrington
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	48
Number of vacancies on the date of inspection:	1

About Dementia Care Thematic Inspections

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

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

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 monitor compliance with specific outcomes as part of a thematic inspection. This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

From:	To:
11 May 2016 09:50	11 May 2016 21:15
12 May 2016 09:15	12 May 2016 17:30

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

Outcome	Provider's self assessment	Our Judgment
Outcome 01: Health and Social Care Needs	Compliance demonstrated	Substantially Compliant
Outcome 02: Safeguarding and Safety	Compliance demonstrated	Substantially Compliant
Outcome 03: Residents' Rights, Dignity and Consultation	Compliance demonstrated	Compliant
Outcome 04: Complaints procedures	Compliance demonstrated	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Substantially Compliant	Compliant
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on six specific outcomes relevant to dementia care. The purpose of this inspection was to focus on the care and quality of life for residents with dementia living in the centre. Thirty nine of the forty eight residents who were living in the centre on the days of the inspection had a diagnosis of dementia.

Fairfield Nursing Home is a purpose built, single storey facility situated approximately one kilometre from Drimoleague. Resident accommodation comprises 39 single bedrooms and five twin bedrooms. For operational purposes the centre was divided into three sections, namely Dromusta House, which accommodates 17 residents,

Rockmount House, which accommodates 16 residents and Deelish House, which also accommodates 16 residents. Residents in Rockmount either had no cognitive impairment or were in the early stages of dementia. Residents in Deelish were considered to have an active phase of dementia and residents in Dromusta had later stage dementia. The decision as to which unit was most suitable for residents was supported by a recognised assessment tool that assessed the degree of cognitive impairment of residents.

The provider had submitted a completed self assessment on dementia care to the Authority with relevant policies and procedures prior to the inspection. The judgements from the self assessment and inspection findings are set out in the table above.

Overall, residents' healthcare and nursing needs were met to a high standard. Residents had access to medical and allied health services. The management of complaints was fully compliant with regulations. Appropriate policies and procedures were in place to protect residents from any form of abuse and residents had access to advocacy services. Inspectors found that staffing arrangements facilitated continuity of care and supported a consistent positive approach to the behaviours and psychological symptoms of dementia (BPSD).

The location, layout and design of the centre was suitable for its stated purpose and met the needs of the resident in a comfortable and homely way. The centre was clean, spacious and decorated to a reasonable standard throughout.

Some improvements, however, were required, particularly in relation to fire safety practices and staffing levels. For example, a fire door was held open with a door wedge and another fire door, that formed part of the compartmentalisation for containing fires, did not have a self closing device attached. Additionally, personal emergency evacuation plans did not contain adequate detail to support the evacuation of non-ambulant residents. In relation to staffing levels, there was only one nurse on duty at night, with four healthcare assistants until midnight and three thereafter, however a recent audit carried out by the centre found deficits in practices at night time. One of the deficits involved the time taken to administer medications, and while changes were instituted following a pharmacist audit, this did not satisfactorily address all issues identified. Other required improvements included that room and fridge temperature records indicated that medications were not stored at appropriate temperatures and some policies required review to ensure they reflected current guidance.

The action plan at the end of this report identifies where improvements are needed to meet the requirements of 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: Health and Social Care Needs

Theme:

Safe care and support

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

Findings:

This outcome sets out the inspection findings relating to healthcare, nursing assessments and care planning. The social care of residents with dementia is comprehensively covered in Outcome 3.

Inspectors focused on the experience of residents with dementia and they tracked the journey of a number of residents with dementia. They also reviewed specific aspects of care such as nutrition and restrictive practices in relation to other residents.

Residents had access to general practitioners (GPs) of their choice. The GPs visited the centre regularly and there was evidence that residents were reviewed frequently. Out-of-hours GP services were also available.

Residents had access to allied healthcare services including dietetics, speech and language, chiropody, physiotherapy and occupational therapy. Dietetics and speech and language services were provided by a company that supplied nutritional supplements. The physiotherapist was available on a private basis and the occupational therapist was provided by a medical supplies company. These services were also available through the public health service, however, there was a long waiting period.

There were systems in place to optimise communication between the resident/families, the acute hospital and the centre. Prospective residents and their families were invited to visit the centre and meet other residents and staff before making the decision to live there.

Residents' files held a copy of their hospital discharge letter and some of the files of residents admitted under 'Fair deal' also held the Common Summary Assessment Report (CSAR), which detailed the assessments undertaken prior to admission. Inspectors examined the files of residents who were transferred to hospital from the centre and found that appropriate information about their health, medications and their specific communication needs were included with the transfer letter.

Records of residents' assessments reviewed by inspectors included comprehensive biographical details, medical history, nursing assessments and life histories. Inspectors primarily focused on the experience of residents with dementia and they tracked the journey of a number of residents with dementia.

Comprehensive nursing assessments were carried out that incorporated the use of validated assessment tools for issues such as risk of falling, risk of developing pressure sores and for the risk of malnutrition. Care plans were developed for issues identified on assessment and, for the most part, these care plans were personalised and provided adequate guidance on the care to be delivered.

There were written policies and procedures in place for end-of-life care and for the management of residents' resuscitation status. Staff provided end of life care to residents with the support of their GP and the palliative care team attached to Bantry General Hospital. There were no residents at active end-of-life stage on the day of the inspection. Religious preferences were documented and there was evidence that they were facilitated. Records indicated that end-of-life preferences were discussed with residents and/or their relatives and these were documented in residents' records. The majority of residents were accommodated in single rooms, so the option of a single room was usually available. Family and friends were facilitated to remain with the resident, including overnight. Family members of a recently deceased resident spoken with by inspectors were complimentary of the care provided to their relative and the manner in which the family were supported throughout the process.

There was a policy and procedure in place to guide practice in relation to the management of nutrition. There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were assessed for the risk of malnutrition on admission and at regular intervals thereafter. Residents' weights were checked on a monthly basis, and more frequently when indicated. There was an effective system of communication between nursing and catering staff to support residents with special dietary requirements. Inspectors found that residents on weight reducing, diabetic, high protein and fortified diets, and also residents who required modified consistency diets and thickened fluids received the correct diet and modified meals were attractively served.

Most residents had breakfasts in the various communal rooms, however, residents that wished to have breakfast in their bedrooms were facilitated to do so. Breakfast was served from approximately 08:30hrs until 10:00hrs or until all residents had eaten. Residents that requested an early breakfast were facilitated. Lunch was served from 12:45hrs to 14:00hrs, and supper was served from 17:00hrs onwards. Fluids were available throughout the day and tea/coffee and snacks were available throughout the day. Residents' independence was supported and a number of residents assisted with tidying up after meals and throughout the day.

On the day of the inspection there were adequate numbers of staff on duty to assist residents with their meals. Residents requiring assistance were assisted by staff in a respectful and dignified manner.

There were written operational policies relating to the ordering, prescribing, storing and

administration of medicines to residents which were implemented in practice. Inspectors found that practices in relation to prescribing and medication reviews met with regulatory requirements and staff were observed to follow appropriate administration practices. Residents' medications were stored in locked cupboards in their bedrooms and only nursing staff had access to the keys. There were no residents assessed as being suitable for self administration of medicines. Improvements, however, were required in relation to the storage of stock medications and medications that required refrigeration. The temperature of both the fridge and the treatment room was in excess of the recommended temperature for medications that were to be stored at room temperature and for those requiring refrigeration.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant.

Judgment:

Substantially Compliant

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

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

Findings:

Inspectors found that measures were in place to protect residents from harm or suffering abuse and to respond to allegations, disclosures and suspicions of abuse.

There was a policy in place on recognising and responding to abuse that covered prevention, detection, reporting and investigating allegations or suspicion of abuse. The policy required review, however, as it did not make reference to recent guidance issued by the health service executive (HSE) as required. All staff spoken with knew what action to take if they witnessed, suspected or had abuse disclosed to them. They also clearly explained what they would do if they were concerned about a colleagues behaviour. The person in charge was also very clear of her role if there were any allegations of abuse. Training records that were reviewed confirmed that staff had received training on recognising and responding to elder abuse.

All residents spoken with said they felt safe and secure in the centre, and felt the staff were supportive. Relatives of residents spoke highly of the care provided by the staff and their caring attitude.

There were policies in place about meeting the needs of residents with responsive behaviour (also known as behavioural and psychological signs and symptoms of dementia) and restrictive practices. Policies were seen to give clear instruction to guide staff practice. Training records reviewed by inspectors indicated that staff were

facilitated to attend training related to the care of people with dementia.

There were care plans that set out how residents should be supported if they presented with responsive behaviour. Staff spoken with were knowledgeable of individual residents behaviour including how to avoid the situation escalating. Inspectors observed staff interacting with residents and where it was obvious that a residents behaviour could escalate, staff were seen to deescalate the behaviour successfully.

There were residents who required the use of bed rails. Risk assessments had been completed for all of these residents. One resident, however, had both a movement alarm and bedrails in place, which would not be in compliance with recommended practice.

Inspectors reviewed incident reports in relation to resident's behaviour and records confirmed the information given to inspectors that there were no recent significant behavioural related incidents.

The centre was not managing the finances of residents. There were appropriate procedures and records in place in relation to the management of residents personal property and possessions.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as substantially compliant. The improvement relates to the need to review the policy on recognising and responding to abuse and the use of a movement alarm for a resident with bedrails in place..

Judgment:
Substantially Compliant

Outcome 03: Residents' Rights, Dignity and Consultation

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:
The preferences of all religious denominations were respected and facilitated. Local clergy from the various religious denominations of residents present in the centre visited regularly. Mass was held in the centre every Thursday for Catholic residents. Residents were facilitated to vote in local and national elections and the returning officer had visited the centre to facilitate residents to vote in the general election. Some residents that wished to vote in the local polling station were supported to do so. Residents had access to television, radio and local and national newspapers.

There was an advocate that attended the centre regularly and met with residents

informally. Contact details were also available of an independent external advocate that was available to the residents. This advocate attended the centre occasionally to meet with residents.

Due to the significant cognitive impairment of a large number of residents, there were no formal residents' meetings. Residents were consulted formally through resident/relative surveys, the majority of which were completed by relatives. Feedback from these surveys was consistently positive. Based on the observations of inspectors, it was evident that residents were consulted informally on a daily basis in relation to how the centre was planned and run.

Inspectors observed staff interacting with residents in an appropriate and respectful manner. Staff and residents were seen to have conversations as staff went about their daily duties in a cordial and relaxed atmosphere. Residents privacy was respected and inspectors observed staff knocking on bedroom doors before entering. Residents had access to a visitors' rooms whereby they could meet with family and friends in private, or could meet in their bedrooms. Most residents had private bedrooms and where bedrooms were shared there was adequate screening between beds to support privacy. Residents choose what they liked to wear and inspectors saw residents looking well dressed, including jewellery and makeup.

Positive interactions between staff and residents were observed during the inspection. As part of the inspection, inspectors spent a period of time observing staff interactions with residents. Inspectors used a validated observational tool (the quality of interactions schedule, or QUIS) to rate and record at five minute intervals the quality of interactions between staff and residents in two communal areas. The scores for the quality of interactions are +2 (positive connective care), +1 (task orientated care, 0 (neutral care), -1 (protective and controlling), -2 (institutional, controlling care). An overview of these observation periods is detailed below

Observations were recorded in the sitting/dining rooms in in all three units. The total observation period was 120 minutes, which comprised four 30 minute periods. For rating purposes, there were 24 five minute observation periods. 21 scores of +2 were given as staff went about their daily duties but engaged residents in conversation on a consistent basis. Staff were knowledgeable of individual residents needs and preferences, addressed residents by their name and conversed with them on issues that appeared to be of interest or relevant to the resident. Staff were also seen to sit with residents periodically and chat with them while making good eye contact. Visitors were seen to come and go, and all were made welcome by staff. Three scores of +1 were given, predominantly when staff were busy preparing to serve food.

While there was a programme of activities available, it was semi-structured in nature and varied based on the judgement of staff on any particular day depending on degree on engagement of residents. The activities programme was built into the daily routine of staff and while some staff concentrated on leading activities such as a sing-along or poetry reading, other staff spent one to one time with residents that were in their bedrooms. Some residents were seen to assist staff with tidying up after meals and throughout the day, an activity in which they appeared keen to participate. Usually after lunch in Deelish unit the curtains were closed and residents were encouraged to relax or

have a nap. On the first day of the inspection a resident from Rockmount came to Deelish to lead on meditation.

Residents were seen to be wearing glasses and hearing aids, to meet their needs. There was a notice in the bedrooms of residents that required more than one set of glasses to identify the purpose for each set of glasses such as for reading or for general use.

This outcome was judged to be compliant in the self assessment, and inspectors also judged it as compliant.

Judgment:

Compliant

Outcome 04: Complaints procedures

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 system in place to ensure that the complaints of residents or their representative were listened to and acted upon. There was a complaints policy that identified the person responsible for managing complaints and also included an appeals process. The complaints procedure was on prominent display in the centre, and summarised in the residents guide.

Throughout the inspection it was clear that residents were familiar with all members of management including the person in charge, and clinical nurse managers. It was apparent to inspectors that residents would find staff easy to approach with any concerns or complaints.

Inspectors viewed the complaints log that contained details of a small number of complaints, the investigation of each complaint, the outcome of the investigation and whether or not the complainant was satisfied with the outcome of the complaint.

This outcome was judged to be compliant in the self assessment, and inspectors judged it as compliant.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

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

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

Findings:

Inspectors found that staff delivered care in a timely and safe manner. During the inspection, residents were seen to receive attention from staff based on their care requirements, for example, responding to the call bell.

Residents appeared to be familiar with staff. Where support to eat and drink was being provided, it was done in a discreet way, however, independence was promoted and residents were not in any way rushed to complete activities. Where residents were able to eat themselves they were supported to do so, for example, some residents had adapted equipment to help them hold items such as cups with handles.

An actual and planned roster was maintained in the centre with any changes clearly indicated. The person in charge was supported by three clinical nurse managers. Inspectors reviewed staff rosters, which showed there was a nurse on duty at all times. The staffing complement included catering, housekeeping, administration and maintenance staff. The centre did not use agency staff as it had sufficient numbers of staff to provide cover in the event of unplanned absences.

The person in charge was requested to review staffing levels at night time as there was only one nurse on duty for 49 residents. There were also four healthcare assistants on duty until 12 midnight, when this number was reduced to three. A recent audit carried out by the centre found deficits in practices at night time and also found that medication administration took a considerable time to complete. To alleviate the work of the nurse on nights, a pharmacist had undertaken a full review of prescriptions, so that only those medications that could not be administered at another time were administered by the nurse on night duty. However, while this measure reduced the workload considerably, there remained a considerable burden on one nurse to supervise care delivery to ensure it was in compliance with the needs of all residents in the centre. Additionally, there was limited capacity for the nurse to care for residents that may be ill or at end of life.

There was a varied programme of training for staff. Records viewed by inspectors confirmed all staff had completed mandatory training in areas such as manual handling; safeguarding and prevention of abuse; and fire safety and evacuation. Staff also had access to a range of education, including training in a specific dementia programme that formed the ethos of the care delivered to residents. A two day refresher programme was scheduled to take place in the week following this inspection. Additional training completed by staff included medication management, cardiopulmonary resuscitation, continence care, food hygiene training for catering staff, hand hygiene and responsive behaviour.

Inspectors reviewed a sample of staff files and found that all of the information required by the regulations was present. There was a staff appraisal process that had lapsed but had recommenced recently.

This outcome was judged to be substantially compliant in the self assessment, and inspectors judged it as moderate non-compliance.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

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

Findings:

Fairfield Nursing Home was a purpose built, single storey facility situated approximately one kilometre from Drimoleague. Resident accommodation comprised 39 single bedrooms and five twin bedrooms. Twenty nine of the single bedrooms and all of the twin bedrooms were en suite with either a toilet, shower and wash-hand basin or toilet and wash-hand basin only. The other 10 bedrooms had a wash-hand basin. For operational purposes the centre was divided into three sections, namely Dromusta House, which accommodated 17 residents, Rockmount House, which accommodated 16 residents and Deelish House, which also accommodated 16 residents. Residents in Rockmount either had no cognitive impairment or were in the early stages of dementia. Residents in Deelish were considered to have an active phase of dementia and residents in Dromusta had later stage dementia. The decision as to which unit was most suitable for residents was supported by a recognised assessment tool that assessed the degree of cognitive impairment of residents.

The location, design and layout of the centre was suitable to meet the individual and collective needs of the resident profile and was in keeping with the centre's statement of purpose. There was a parking area to the front of the premises and further parking was available at the rear. Appropriate heating, lighting and ventilation were in place throughout the premises.

On the days of inspection the centre was clean, bright and in a good state of repair. The centre was homely and many of the bedrooms were personalised with residents' personal possessions and memorabilia. There was an ongoing process of redecoration of bedrooms and residents were consulted in relation to issues such as paint colours. Corridors were painted in bright colours and there were murals, paintings and various other artefacts and memorabilia on walls that contributed to a stimulating environment. The doors to the bedrooms in Deelish had an overlay that had the effect of making them appear like "front doors" and were all different colours to support residents identify their bedrooms.

Communal space comprised combined sitting rooms/dining rooms, which were designed and furnished to reflect a homely atmosphere. Deelish unit in particular, provided an environment that was homely and was furnished with comfortable couches, chairs and other furniture such as kitchen cupboards. There was a secure, well maintained patio area, which was enclosed and could be accessed safely by both visitors and residents.

There were adequate catering facilities. Separate facilities were available for staff and included an area for changing and storage. Following the previous inspection, staff changing facilities were relocated to another area of the premises to allow for the creation of an additional assisted shower/bathroom.

In addition to ensuite facilities, there were two bathrooms, one of which contained a bath, shower and toilet and the other contained a shower and toilet.

There was only one sluice room in the centre that had been refurbished since the last inspection. It contained a sluice sink, racking for bedpans/urinals and a wash-hand basin had been installed. There was, however, no bedpan washer/macerator and inspectors were not satisfied that sluicing facilities were suitable to the needs of the residents living in the centre. This action is addressed under Outcome 8.

There were laundry facilities and a wash-hand basin had been installed here following the last inspection. Records were available demonstrating the preventive maintenance of equipment such as hoists, beds and chairs.

This outcome was judged to be substantially compliant in the self assessment, and inspectors agreed with this judgement.

Judgment:
Compliant

Outcome 07: Health and Safety and Risk Management

Theme:
Safe care and support

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

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

Findings:

At the last inspection it was identified that the emergency plan was inadequate, that medication cupboards stored in residents' bedrooms were not risk assessed, fire drills were not held frequently and not all staff had received up-to-date training in fire safety.

On this inspection it was found that these actions were satisfactorily addressed.

However, some required improvements were identified on this inspection. For example:

- the door to the communal unit in Deelish was held open with a door wedge
- the smoke seal on a number of fire doors was damaged. These were repaired on the

days of inspection, however, inspectors requested that these be reviewed by a suitably qualified person to ensure they were adequate

- fire doors on the corridors were double doors and one of these doors was open on the morning of the first day of the inspection, but did not have a self closing device to ensure it closed in the event the fire alarm was activated
- personal emergency evacuation plans did not contain adequate detail in relation to the process for evacuating non-ambulant residents and did not identify which residents had evacuation sheets in place on their beds
- while fire drills were held frequently, inspectors found that the fire drill records required more detail in order to demonstrate that all concerned were aware of the procedure and that there is sufficient staff and equipment present at all times to facilitate evacuation in a timely fashion. For example, the records did not indicate the scenario simulated, including the time of day or night the drill took place. The records did not indicate the number of residents, or staff participating as residents, evacuated. The records did not indicate the time taken to evacuate the fire compartment concerned.

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:

John Greaney
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:	Fairfield Nursing Home
Centre ID:	OSV-0000227
Date of inspection:	11/05/2016
Date of response:	13/06/2016

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 01: Health and Social Care Needs

Theme:

Safe care and support

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

Improvements were required in relation to the storage of stock medications and medications that required refrigeration. The temperature of both the fridge and the treatment room was in excess of the recommended temperature for medications that were to be stored at room temperature and for those requiring refrigeration.

1. Action Required:

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

Under Regulation 29(4) you are required to: Store all medicinal products dispensed or supplied to a resident securely at the centre.

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

Our electrician called to check the medication storage fridge and deemed it to be in perfect working order. A new thermometer probe was purchase and installed on the 16/05/16 and all recordings are within normal limits since. A ceiling extractor fan has been ordered for the treatment room.

Proposed Timescale: 15/07/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

The policy on recognising and responding to abuse required review as it did not make reference to recent guidance issued by the health service executive (HSE) as required.

2. Action Required:

Under Regulation 04(3) you are required to: Review the policies and procedures referred to in regulation 4(1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.

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

The policy has been reviewed and updated and HSE guidance included.

Proposed Timescale: 17/05/2016

Theme:

Safe care and support

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

One resident had both a movement alarm and bedrails in place, which would not be in compliance with recommended practice.

3. 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:

The movement alarm has been removed and the bedrails remain in place from 8pm to

8am as per risk assessment.

Proposed Timescale: 12/06/2016

Outcome 05: Suitable Staffing

Theme:

Workforce

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

The person in charge was requested to review staffing levels at night time as there was only one nurse on duty for 49 residents. There were also four healthcare assistants on duty until 12 midnight, when this number was reduced to three. To alleviate the work of the nurse on nights, a pharmacist had undertaken a full review of prescriptions so that only those medications that could not be administered at another time were administered by the nurse on night duty. However, while this measure reduced the workload considerably, there remained a considerable burden on one nurse to supervise care delivery to ensure it was in compliance with the needs of all residents in the centre. Additionally there was limited capacity for the nurse to care for residents that may be ill or at end of life.

4. 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 Nurses meeting was held on 08/06/2016 to discuss a review of night staffing levels. The current night nurses stated that they were happy with the current staffing levels but after discussion it was agreed that an extra Nurse from 8pm – 11pm would greatly benefit the timely administration of medications. To facilitate this it was decided to remove the night carer from 8pm to midnight and replace with a nurse on a trial basis.

Proposed Timescale: 03/07/2016

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

There was no bedpan washer/macerator and inspectors were not satisfied that sluicing facilities were suitable to the needs on the residents living in the centre.

5. 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:

In 2015 our Sluicing room was redesigned and updated and the plans were forwarded to you. In line with Standards for the prevention and Control of healthcare associated infections we assessed and implemented the use of disposable bedpan inserts and urinals at that time. A commode remains in the room of the user. We are satisfied that our policy and procedures are successfully implemented. All the staff are educated in infection control. Our clinical waste provider is Initial Medical who provides us with a regular collection.

Proposed Timescale: 03/08/2016

Theme:

Safe care and support

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

Some improvements were required in relation to fire safety. For example:

- the door to the communal unit in Deelish was held open with a door wedge
- the smoke seal on a number of fire doors was damaged. These were repaired on the days of inspection, however, inspectors requested that these be reviewed by a suitably qualified person to ensure they were adequate
- fire doors on the corridors were double doors and one of these doors was open on the morning of the first day of the inspection, but did not have a self closing device to ensure it closed in the event the fire alarm was activated
- while fire drills were held frequently, inspectors found that the fire drill records required more detail in order to demonstrate that all concerned were aware of the procedure and that there is sufficient staff and equipment present at all times to facilitate evacuation in a timely fashion. For example, the records did not indicate the scenario simulated, including the time of day or night the drill took place. The records did not indicate the number of residents, or staff participating as residents, evacuated. The records did not indicate the time taken to evacuate the fire compartment concerned.

6. Action Required:

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

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

To alleviate the use of the door wedge our electrician is installing a self closing device. The smoke seals and fire doors has been reviewed by our Fire engineer and whatever needs to be replaced is being seen to by him.

From now on fire drills will be recorded in more detail and will be documented accordingly.

Proposed Timescale: 15/07/2016

Theme:

Safe care and support

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

Personal emergency evacuation plans did not contain adequate detail in relation to the process for evacuating non-ambulant residents and did not identify which residents had evacuation sheets in place on their beds

7. Action Required:

Under Regulation 28(2)(iv) you are required to: Make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and safe placement of residents.

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

The personal emergency evacuation plan has now been updated and we are sourcing extra fire evacuation sheets.

Proposed Timescale: 30/06/2016