

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Blackrock Abbey Nursing Home
Centre ID:	OSV-0000118
Centre address:	Cockle Hill, Blackrock, Dundalk, Louth.
Telephone number:	042 932 1258
Email address:	Helen@talbotgroup.ie
Type of centre:	A Nursing Home as per Health (Nursing Homes) Act 1990
Registered provider:	Orkcalb Limited
Provider Nominee:	Helen Murphy
Lead inspector:	Catherine Rose Connolly Gargan
Support inspector(s):	Leanne Crowe
Type of inspection	Unannounced Dementia Care Thematic Inspections
Number of residents on the date of inspection:	59
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:
28 July 2016 09:15	28 July 2016 18:30
29 July 2016 08:15	29 July 2016 14:00

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	Substantially Compliant	Non Compliant - Moderate
Outcome 02: Safeguarding and Safety	Substantially Compliant	Non Compliant - Major
Outcome 03: Residents' Rights, Dignity and Consultation	Substantially Compliant	Non Compliant - Moderate
Outcome 04: Complaints procedures	Substantially Compliant	Compliant
Outcome 05: Suitable Staffing	Substantially Compliant	Non Compliant - Moderate
Outcome 06: Safe and Suitable Premises	Non Compliant - Moderate	Non Compliant - Moderate
Outcome 07: Health and Safety and Risk Management		Non Compliant - Moderate
Outcome 12: Notification of Incidents		Non Compliant - Moderate

Summary of findings from this inspection

This inspection report sets out the findings of a thematic inspection which focused on specific outcomes relevant to dementia care. The inspection also followed up on progress with completion of actions required to address non-compliances with the regulations from the last inspection of the centre in March 2015. There were twelve actions required in the action plan from the previous inspection and four were found to be satisfactorily completed. Inspectors also followed up on unsolicited information received in relation to inadequate staffing levels. This information was substantiated by the findings on this inspection.

As part of the thematic inspection process, providers were invited to attend information seminars given by the Health Information and Quality Authority (HIQA). In addition, evidence-based guidance was developed to guide the providers on best practice in dementia care and the inspection process.

Prior to the inspection, the person in charge completed the provider self-assessment and scored the service against the requirements of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 and the National Quality Standards for Residential Care Settings for Older People in Ireland. The previous table outlines the self-assessment and the inspectors' rating for each outcome.

Inspectors met with residents and staff members during the inspection. They also tracked the journey of four residents with dementia within the service. They observed care practices and interactions between staff and residents who had dementia using a validated observation tool. Documentation such as care plans, medical records, medication documentation and staff training records and policies were reviewed.

The centre catered for residents with a range of needs. While the centre predominantly accommodates older persons, 19 of the 59 people residing in the centre on the day of inspection had an intellectual disability. The provider advised that plans were in progress to designate all accommodation in the centre for care of older persons. On this inspection 24 residents had a dementia related condition, 15 of whom had a formal diagnosis of dementia. Improvements were required in relation to staff training to ensure staff were skilled to support residents and their families and to provide person-centred care. A staff recruitment programme was underway which was necessary to ensure residents were appropriately supervised, assisted to meet their needs and were provided with meaningful activities to meet their interests and capabilities. An activity co-ordinator was recently appointed and due to commence working with residents in the centre.

Each resident was assessed prior to admission to ensure the service could meet their needs and to determine the suitability of the placement. Following admission, residents had an assessment and their care plan was developed. However, not all residents had a care plan to meet their assessed needs and care plan did not consistently direct care. The health needs of residents were generally met however, improvements were required to ensure residents healthcare including medication management was provided to a high standard. Residents had access to medical services and a range of other health services and evidence-based nursing care was provided.

There was evidence of good interdisciplinary approaches in the management of behaviours that challenge. However some residents did not have the necessary comprehensive support plans and management strategies in place to guide a consistent approach by staff and ensure positive outcomes for the residents. Findings on this inspection did not provide adequate assurances that residents with behavioural and psychological symptoms of dementia (BPSD) were appropriately

supported and managed and as such posed a risk to themselves or other residents. Due to the level of risk identified, inspectors issued an immediate action plan requiring action to be taken to ensure all residents in the centre were appropriately safeguarded, to be completed within five working days. The provider responded to HIQA within the timescale specified advising a schedule of actions underway to meet all residents' safeguarding and safety needs.

The premises is purpose-built and residents are accommodated over two floors. The arrangement whereby residents from the older person service are accommodated on the ground floor had access limitations to safe external areas and movement around the centre did not provide a therapeutic environment that promoted a good quality of life for residents including residents with dementia. The provider/person in charge had identified this and advised inspectors that actions underway to change the resident profile of the centre to an older person service would address this situation.

These issues are discussed further in the body of the report. 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: Health and Social Care Needs

Theme:

Safe care and support

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

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

Findings:

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

The centre catered for residents with a range of needs. While the centre predominantly accommodates older persons, 19 of the 59 residents accommodated in the centre on the day of inspection had an intellectual disability. The provider advised that plans were in progress to designate all accommodation in the centre for care of older persons. On the day of this inspection, there was a total of 40 residents in receipt of older person care, two of whom were in hospital. Twenty four residents had dementia, 15 of whom had a formal diagnosis of dementia.

Inspectors focused on the experience of residents with dementia on this inspection. They tracked the journey of four residents with dementia and also reviewed specific aspects of care such as safeguarding, nutrition, wound care and end-of-life care in relation to other residents with dementia in the centre.

There were systems in place to optimise communications between the resident/families, the acute hospital and the centre. The person in charge or senior nurse visited prospective residents in hospital or their home in the community prior to admission. Prospective residents and their families were welcomed into the centre to view the facilities and discuss the services provided before making a decision to live in the centre. This gave residents and their families information about the centre and also ensured them that the service could adequately meet their needs.

A copy of the Common Summary Assessments (CSARs), which details pre-admission assessments undertaken by the multidisciplinary team for residents admitted under the 'Fair Deal' scheme, was available to the person in charge but not kept routinely in residents' files. However, the files of residents' admitted to the centre from hospital held their hospital discharge documentation including a medical summary letter, multidisciplinary assessment details and a nursing assessment. Inspectors examined the

document used for residents who were transferred to hospital from the centre. This summary document recorded appropriate information about residents' health, medications and nursing needs. However there was limited reference to information to support residents with BPSD or responsive behaviours. A communication passport was not currently in use for residents with communication needs going to hospital at the time of this inspection. Inspection findings supported conclusion that this documentation would be of value in supporting the communication needs of residents with dementia accessing services outside the centre to outline their individual preferences, dislikes and strategies to prevent or to support those with physical and psychological symptoms of dementia. The nutritional and hydration needs of residents with dementia were met; however, improvement was required in dining arrangements. Residents were generally protected by safe medicine management policies and procedures but some improvements were required in medication documentation procedures.

There was evidence that timely access to health care services was facilitated for all residents. The person in charge confirmed that a number of GPs were attending to the needs of the residents, giving residents a choice of general practitioner. Residents attended out-patient appointments and were referred as necessary to the acute hospital services. Documentation and residents spoken with confirmed they had access to GP care including out-of-hours medical care. Some residents from the locality were facilitated to retain the services of the GP they attended prior to their admission to the centre. Residents had good access to allied healthcare professionals including physiotherapy provided by a physiotherapist employed by the provider to work with residents two days each week in the centre. Occupational therapy, dietetic, speech and language therapy, dental, ophthalmology and podiatry services were also available to residents as necessary. Community psychiatry of older age specialist services and a psychologist attended residents in the centre with dementia and supported GPs and staff with managing residents experiencing behavioural and psychological symptoms of dementia (BPSD) as needed. However, the findings on this inspection confirmed that recommendations made by psychiatric services were not satisfactorily implemented and management plans to direct care were not in place. This finding is discussed further in outcome 2. Residents' positive health and wellbeing was promoted with regular physiotherapy, an annual influenza vaccination programme, regular blood profiling and medication reviews. Residents in the centre had access to palliative care services for support with management of their pain and for symptom management during 'end of life' care if required.

The centre was in the process of transitioning from paper-based documentation to a computerised resident documentation management system. The computerised data management system in the process of implementation was password protected to ensure residents' personal information was securely stored. Its implementation was also supported by a support and training programme for staff. Inspectors were advised that the system will give care staff access to residents' care interventions and improve their input into record keeping of care interventions they completed.

There were systems in place to meet the health and nursing needs of residents with dementia. There was evidence of on-going work to improve assessment and documentation of residents' needs since the last inspection in March 2015. However, inspectors found that further improvement was required to ensure that each resident's

needs were comprehensively documented in care plans that clearly directed care interventions. For example, some resident needs were not reflected in a documented care plan including care of residents with responsive behaviours. In addition, interventions often lacked sufficient detail to direct care.

Assessments of residents' needs were carried out within 48 hours following admission and care plans were developed based on assessments of need and in line with residents changing needs. The assessment process involved the use of validated tools to determine each resident's risk of malnutrition, falls, their level of cognitive function and skin integrity among others. Care plans were updated routinely on a three to four-monthly basis or to reflect residents' changing care needs as necessary. Inspectors found that all staff spoken with were knowledgeable regarding residents' likes, dislikes and needs. Although at an early stage and not completed for all residents, arrangements were in place to complete residents' social/recreational assessments. This was being done with the support of residents and their relatives where appropriate, to provide information to inform the communication and activation needs of residents with dementia. While there was evidence of involvement of residents and their families in residents' care, improvement was required to ensure they were consulted with in relation to care plan development and reviews thereafter. Residents had a section in their care plan that addressed their communication needs. However, the communication policy document available required improvement to include strategies to inform communication with residents who had dementia.

Staff provided end-of-life care to residents with the support of their medical practitioner and community palliative care services as necessary. No resident was in receipt of palliative care services at the time of inspection. A pain assessment tool for residents, including residents who were non-verbal was available to support pain management. Inspectors reviewed a number of 'End of life' care plans but found that they did not comprehensively outline the physical, psychological and spiritual needs of residents. Residents' individual wishes regarding place for receipt of 'end of life' care were not recorded. Advanced directives were in place for some residents regarding resuscitation procedures. However improvement was required in recording of signatures by all members of the multi-disciplinary team involved in the decision-making process. This documentation recorded family input on behalf of the resident in most cases in the documentation reviewed. However, there was room for improvement to ensure residents were involved in these decisions where appropriate. Residents had access to an oratory on the first floor. Single rooms were available for 'end of life' care and relatives were accommodated to stay overnight with residents at the 'end of life' stage of their lives. Staff outlined how residents' religious and cultural practices were facilitated. Members of the local clergy from the various religious faiths provided pastoral and spiritual support to residents. Inspectors observed that staff were trained to administer subcutaneous fluids to treat dehydration in order to avoid unnecessary hospital admissions at this time.

There were care procedures in place to prevent residents developing pressure related skin injuries. Each resident had their risk of developing pressure sores assessed. Pressure relieving mattresses, cushions and repositioning schedules were in use to mitigate risk of ulcers developing. The provider/person in charge discussed care procedures for six residents with pressure related skin injuries. Since the inspection the

Health Information and Quality Authority (HIQA) were notified of these incidents that occurred in the centre since 01 April 2016. While inspectors were told on this inspection that these wounds had improved including one resident with a pressure ulcer receiving further treatment in hospital on the days of this inspection, preventative pressure ulcer management required review to ensure residents' needs were comprehensively met. Following this inspection, a review of preventative pressure ulcer management by the provider/person in charge was requested by HIQA for return on 20 August 2016. Inspectors reviewed procedures in place for wound assessment and care and found that appropriate procedures were in place. The nutritional needs of residents with pressure ulcers were reviewed by a dietician and tissue viability specialist services were available to support staff with management of pressure wounds that were deteriorating or slow to heal.

There were systems in place to ensure residents' nutritional needs were met, and that they did not experience poor hydration. Residents were screened for nutritional risk on admission and reviewed regularly thereafter. Residents' weights were checked routinely on a monthly basis or more frequently where indicated. Nutritional assessment and care plans were in place that outlined the recommendations of dieticians and speech and language therapists where appropriate. Systems were in place for recording residents' nutritional and fluid intake where required. Inspectors saw that residents had a choice of hot meals for lunch and tea. 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 and fortified diets, and residents who required modified consistency diets and thickened fluids, received the correct diets. There was one large spacious dining room available on the first floor which was observed to be overcrowded at mealtimes. Meals were provided to residents in one sitting. There was also a number of residents who ate in the sitting rooms at mealtimes. Although staff supported residents requiring assistance, not all residents received assistance in a timely manner when they needed it. The provider/person in charge advised inspectors that this finding had been identified and plans in place to change the purpose of the centre would ensure all residents had access to adequate dining facilities.

There were arrangements in place to review accidents and incidents within the centre, and residents were assessed on admission by the centre's physiotherapist and regularly thereafter for risk of falls. There was evidence of identification and implementation of learning in practice as outcomes of fall reviews. HIQA was notified of two incidents of residents falling since May 2015, one of whom sustained a fracture. All residents at risk of falling were appropriately risk assessed and controls such as hip protection and sensor alarm equipment was in place.

There were written operational policies informing ordering, prescribing, storing and administration of medicines to residents. Inspectors found that practices in relation to prescribing and medication reviews met with regulatory requirements with the exception of an anticoagulant medication and instruction to crush residents' tablet preparations. An electronic pharmacy generated medication administration recording system was in place. The system was password protected and required internet access to operate. Medications administered were verified by a tick entered by the user. Residents' original medication prescriptions were in hard-copy format. Nurses were involved in transcribing medication prescriptions. While medications were signed by each resident's GP,

transcribed medication prescriptions viewed by an inspector were not dual signed in line with nurses' professional guidelines. Residents with swallowing deficits and requiring lump free consistency oral intake were intermittently administered their medications in tablet format. Medications to be administered in crushed format were not individually signed and crushing of tablet preparations was directed by an additional document kept in residents' information files.

The pharmacist who supplied residents' medications was facilitated to meet their obligations to residents. While there were procedures for the return of out of date or unused medications, some medications in the medication storage trolley were out of date. Systems were in place for recording and managing medication errors. An action plan from the last inspection in March 2015 regarding prescribing of wafarin anticoagulation medications was not satisfactorily completed. Procedures detailed in the medication management policy for management and recording of wafarin therapy were not consistently reflected in practice.

Judgment:

Non Compliant - Moderate

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

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

Findings:

A comprehensive policy was available to inform management of responsive behaviours. However, practices in the centre did not reflect this policy. Inspectors findings on this inspection did not provide adequate assurances that residents with behavioural and psychological symptoms of dementia were appropriately supported and managed and as such posed a risk to themselves or other residents. There was evidence of some incidents of responsive behaviours that had a negative impact on the residents themselves and on others. Inspection findings did not support satisfactorily management of a number of incidents. Residents with BPSD (Behaviours that challenge/responsive behaviours) were reviewed by community psychiatric and clinical psychology services. However, recommendations made in terms of supervision arrangements were not consistently implemented. Residents exhibiting responsive behaviours did not have positive behaviour support plans to inform their care and supervision needs. Some de-escalation procedures were not appropriate. The inspectors reviewed staff training records and saw that all staff had not received up to date training in managing residents with BPSD or behaviours that challenge.

Due to the level of risk identified, inspectors issued an immediate action plan to the provider during the inspection feedback meeting requiring action to be taken to ensure all residents in the centre were appropriately safeguarded, to be completed within five

working days. The provider responded to HIQA within the timescale specified advising a schedule of actions underway to meet all residents' safeguarding and safety needs.

A policy document was available to inform prevention of abuse and management of any allegations, suspicions or disclosures of abuse. Staff interviewed were familiar with the policy and knew what to do in the event of an allegation, suspicion or disclosure of abuse and they were aware of their responsibility to report. There were no allegations of abuse under investigation in the centre at the time of this inspection. However, there were peer to peer incidents recorded that were not comprehensively investigated to out rule abuse.

The centre maintained day to day expenses for a number of residents and inspectors findings did not support comprehensive management procedures. Inspectors reviewed the systems in place to safeguard residents' finances which included a review of a sample of records of monies handed in for safekeeping. Residents' money was kept in a locked safe in the administration office and in a locked press in the nurses office. Money kept in the administration office was supported with records of all transactions. All entries were signed and checked by two staff. The system was found to be sufficiently robust to protect residents and staff. However residents' money kept at clinical/ward level was not supported by similar transparent processes.

Residents freedom of movement was restricted within the centre and the fact that residents on both floors could not access a safe and secure outdoor area did not create an optimal environment to minimise the risk of residents developing BPSD or responsive behaviours. A balcony area was available to residents on the first floor. However, this area required constant supervision and did not meet the expressed wishes of one resident.

There was a centre-specific restraint policy which aimed to promote a restraint-free environment. Bedrails were used for approximately 50% of residents in the centre. While alternatives such as low beds, crash mats and bed alarms were in use for a number of residents, inspectors found that many bedrails in use did not reference adequate assessment and together with the practice of securing many internal and all external doors did not reflect the national restraint policy as published by the Department of Health. On the last inspection in the centre in March 2015, inspectors found that documentation in relation to the use of chemical restraint was not always up to date and in line with national restraint policy. Inspectors findings on review of a resident's documentation referencing administration of a chemical restraint on three occasions in January and February 2016 was not consistently recorded on a 'clinical decision form' and as such did not evidence that administration was in line with national restraint policy guidelines.

Judgment:

Non Compliant - Major

Outcome 03: Residents' Rights, Dignity and Consultation

Theme:

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

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

Findings:

Residents with dementia were consulted with and supported to participate in the organisation of the centre. While resident meetings were occurring there was an extended intervals between the last three meetings and did not reflect meeting frequency as stated in the centre's statement of purpose. The last resident meeting was held in June 2016. The provider/person in charge advised inspectors that residents' meetings were now scheduled on an increased frequency to ensure residents were informed about and involved in the plans underway to change the resident profile in the centre. The next residents' meeting was scheduled for September 2016. Overall residents' privacy and dignity was respected and residents were supported to make choices about their day-to-day routines such as the times they retired to and got up in the mornings. However improvements were required in access to suitable dining facilities and to a safe and secure external area as discussed in outcome 6. Some residents rights were not upheld. For example ten residents from the older person service who were accommodated on the ground floor could not independently access the facilities on the first floor or return to their bedrooms during the day if they wished to do so. The provider/person in charge had identified this and advised inspectors that actions underway to change the resident profile of the centre to an older person service would address this situation.

Inspectors met with a project co-ordinator recruited by the service to review the activation needs and opportunities available for residents in the centre pending commencement of a recently recruited activity co-ordinator. Addressing the social needs of residents was integral to the role of healthcare assistants. While a schedule of activities was in place and displayed for residents over seven days each week, there was an absence of comprehensive assessment to ensure each resident with dementia had access to activities that met their individual interests and capabilities. Some activities available to residents in the centre were repetitive and were mainly group focused. Scheduled activities included art therapy facilitated by an external therapist, exercise, sing-along, daily newspaper readings, aromatherapy, walks when weather permitted and beauty care. Art therapy facilitated on the day of inspection was not well attended by residents. Significantly improved assessment for residents with dementia was required to ensure that activities provided met the interests and capabilities of residents with dementia including whether 1:1 or small group activities were most appropriate to meet their needs. While aromatherapy was scheduled on one one occasion each week. a robust sensory focused activity programme was not available for residents with dementia.

Inspectors observed the quality of interactions between staff and residents using a validated observational tool to rate and record the quality of interactions between staff and residents at five minute intervals in the sitting rooms and the dining-room area. 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). The scores reflect the effect of the interactions on the majority of residents. Inspectors' observations concluded that while there was some evidence of positive connective care with individual residents, this finding was not evident for all residents with dementia. Not all opportunities were taken when completing tasks of care to positively engage with residents and there were several occasions where staff interrupted their care of a resident to provide care to another and occasions where individual residents were requested to wait for attention until staff completed care activities for other residents. This finding did not reflect a high standard of person-centred care that respected residents' dignity.

There were no restrictions on visitors and there were a number of areas in the centre on both floors, where residents could meet visitors in private. These areas were styled in a way that facilitated quiet rest or meeting with a small group of visitors. Residents on the first floor had access to a library where they could also enjoy refreshments with their relatives.

Inspectors saw that staff made every effort to ensure that each resident with dementia received care that respected their privacy when providing personal care. Staff were observed knocking on bedroom and bathroom doors. Bedroom and toilet doors were closed during personal care activities. Curtain screens in twin bedrooms were provided and closed accordantly. Inspectors observed staff interacting with residents in an appropriate and respectful manner. All residents were accommodated in single or twin bedrooms, 50% of which had en-suite toilet and shower facilities. There were additional communal toilets and bathroom/shower facilities provided to meet the personal care needs of residents.

Judgment:

Non Compliant - Moderate

Outcome 04: Complaints procedures

Theme:

Person-centred care and support

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

No actions were required from the previous inspection.

Findings:

There was a policy and procedures in place for the management of complaints. The policy identified the nominated person to deal with complaints, as well as the person nominated to ensure that complaints are appropriately recorded and responded to. However the policy required improvement to accurately reflect the appeals processes available to complainants.

There was a simplified complaints procedure prominently displayed in the reception of the centre, which clearly outlined the processes in ways that were accessible to all

residents.

The centre maintained a complaints log, which inspectors examined on the day of the inspection. Both verbal and written complaints were recorded, and these included details of each complaint, the investigation undertaken and the outcome of the investigation. The satisfaction of the complainant was also recorded in each instance.

Inspectors spoke with staff on the day of the inspection, who were able to describe how they would support residents, including those with dementia, to make a complaint.

Judgment:

Compliant

Outcome 05: Suitable Staffing

Theme:

Workforce

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

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

Findings:

Inspectors' findings on this inspection did not provide adequate assurances that there were sufficient numbers and skill mix of staff to meet the assessed needs of the residents.

The provider/person in charge advised inspectors that a staff recruitment campaign was underway with a number of new staff recruited. However on the day inspectors found that staffing levels were not sufficient to provide adequate supervision of residents as well as social care provision. While there were residents with increased supervision needs as recommended by medical specialists, inspectors observed evidence of incidents occurring that put individual residents at risk of injuring themselves or others.

Arrangements for the supervision of vulnerable residents were inadequate. Inspectors observed one staff member being responsible for the simultaneous supervision of a number of day rooms. Staffing levels did not support the provision of person centre care. For example inspectors observed numerous instances of staff having to stop providing care to individual residents in order to attend to the needs of another resident. In addition there were inadequate staffing levels to provide timely assistance at meal times. Several staff spoken with told inspectors that the staffing levels provided were not sufficient to enable them to meet the needs of residents. Inspectors observed a resident requesting to go outside on two occasions but staff were unable to facilitate this request as they were busy with meeting the needs of other residents. Inspectors also observed that a member of new staff was not appropriately supervised.

The person in charge had completed appraisals for all staff for 2016, and a training

needs analysis had been carried out to identify training requirements. The person in charge told inspectors that training in behaviours that challenge/ BPSD was part of the planned training programme for the coming months, with the programme beginning for new staff in August 2016. In the last inspection, it was identified that while training and education was being provided to staff, it was not always tailored to the assessed needs of the residents. In the most recent inspection, inspectors found this still to be the case. Training records showed that while all staff had received mandatory training in moving and handling practices, fire safety and the prevention of abuse, not all staff had received training in managing behaviours that challenge/ BPSD and training that had been completed had taken place in 2010 and 2011. Findings on inspection indicated that the support and management needs of residents with behaviours that challenge/ BPSD were not met.

There was also evidence of Improvements required in staff supervision to ensure that safe moving and handling procedures were used for residents at all times. While an induction program was in place for newly recruited staff members, evidence gathered on the day of the inspection indicated that a robust system for the supervision of new staff was required in the centre.

An actual and planned roster was available for review by inspectors, with changes clearly indicated.

A sample of staff files was reviewed by inspectors, and all necessary documentation was in place as required by Schedule 2 of the regulations. There was also evidence that Garda Vetting was being processed for recently recruited staff members.

Documentation provided to inspectors showed that all nursing staff had up-to-date registration with An Bord Altranais.

There were no volunteers currently working in the centre.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

The inspectors found that most aspects of the premises met the needs of the residents. However, the communal facilities and the limitations on free access for residents on the ground floor to the first floor and their bedrooms as they wished did not provide a therapeutic environment for residents including residents with dementia accommodated

on the ground floor.

The centre is a purpose built two-storey building, which accommodates a maximum of 60 residents in single and twin bedrooms. On the day of the inspection, it was found to be clean and well-maintained with suitable heating, lighting and ventilation. The centre had a number of communal areas for residents including two sitting rooms, a library, a conservatory and an outdoor balcony area accessible from the conservatory. Tables and seating were available for residents' use on the balcony. A large, bright dining room was decorated in a domestic style and featured a pictorial menu board that was changed daily. However, inspectors observed that the comfort of residents was compromised in one sitting room located between the conservatory and dining-room due to pedestrian traffic through this area, especially before and after mealtimes.

The provider/person in charge and staff demonstrated resourcefulness and creativity with work done in refurbishing communal areas on the first floor to provide a comfortable and therapeutic environment for residents with dementia. A variety of artwork and photos were also displayed on all of the corridors, and contrasting borders were painted around doorways. Signage and cues to support residents with dementia were found to be in use in several areas of the centre. Handrails were in place in corridors and a lift was available to support movement throughout the centre. However, residents on the ground floor did not have free movement between communal areas on the first floor and their bedrooms.

Bedrooms were found to be of adequate size to accommodate residents, their belongings and any assistive equipment they might require. Residents' names were displayed outside their door, and inspectors observed that many residents had chosen to personalise their rooms with belongings. While curtains provided privacy for residents sharing twin bedrooms, the layout of the rooms did not allow one resident in each room to engage in watching television due to placement of their personal television.

All twin bedrooms had ensuite facilities for residents, and there were a number of toilets and shower rooms located across the first floor of the centre. While the majority of toilets and shower rooms had grab rails in place to support residents, a grab rail was required in one of the shower areas.

Judgment:

Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management

Theme:

Safe care and support

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

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

Findings:

The action plans from the previous inspection in March 2015 regarding safe moving and handling procedures and staff knowledge of fire evacuation procedures were examined on this inspection under this outcome.

Inspectors spoke with staff in relation to fire safety and evacuation. Staff spoken with demonstrated adequate knowledge in relation to fire evacuation procedures including the procedure to be followed in the event of the fire alarm sounding and the location of personal evacuation plans (PEEPs) for residents. Staff all reported that they had received fire training including evacuation procedures. This was confirmed by staff training record documentation.

On the last inspection in March 2015, an inspector observed an incident where practice did not follow current moving and handling practices. Staff training records confirmed that all staff had received training in safe moving and handling procedures. However, inspectors observed several incidents of unsafe moving and handling of residents from sitting to a standing position on this inspection. This finding was brought to the attention of the provider/person in charge at the inspection feedback meeting.

Judgment:

Non Compliant - Moderate

Outcome 12: Notification of Incidents

Theme:

Effective care and support

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

No actions were required from the previous inspection.

Findings:

Inspectors found that not all incidents were appropriately notified. The following incidents were not notified to HIQA;

- Three incidents of chemical restraint use in January and February 2016.
- An incident of attempted self-harm that resulted in a hospital admission.
- Peer to peer incidents that referenced potential abuse.

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:

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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:	Blackrock Abbey Nursing Home
Centre ID:	OSV-0000118
Date of inspection:	28/07/2016
Date of response:	07/09/2016

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

The medication management policy was not always implemented: Medications to be administered in crushed format were not individually signed. Where verbal orders were received for wafarin, a designated and centre-specific wafarin chart was used to record this information. This chart was not outlined in the medication management policy.

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

The communication policy document available required improvement to include strategies to inform communication with residents who had dementia.

1. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

- We are adjusting our medication prescription charts to include individual signatures for each crushed medication.
- We are updating our medication management policy to include the use of the warfarin form.
- We are updating our communication policy to include strategies to inform communication with residents who have dementia.

Proposed Timescale: 30/09/2016

Theme:

Safe care and support

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

Some resident needs were not reflected in a documented care plan.

Interventions to direct care actions were not clearly stated in some care plans.

2. Action Required:

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

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

- In line with the implementation of epiCare all care plans are being reviewed to ensure they accurately reflect all the needs of the resident. To-date a number have already been completed.
- Having clearly identified residents needs the care plans will also be updated to ensure the appropriate interventions to direct care are clearly documented.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

While there was evidence of involvement of residents and their families in residents' care, improvement was required to ensure they were consulted with in relation to care

plan development and reviews thereafter.

3. 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:

Reviews of care plans will take place no less frequently than at four monthly intervals in consultation with the resident concerned and where appropriate the resident's family.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

Findings on this inspection confirmed that recommendations made by psychiatric services for some residents were not satisfactorily implemented and management plans to direct their care were not in place.

Residents with swallowing deficits and requiring lump-free consistency oral intake were intermittently administered their medications in tablet format.

4. Action Required:

Under Regulation 06(2)(b) you are required to: Make available to a resident medical treatment recommended by a medical practitioner, where the resident agrees to the recommended treatment.

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

- A review of all care plans has commenced with a number already completed. In future all care plans will clearly document the appropriate interventions to give effect to the recommendations of all health professionals. Management plans are now in place to direct care in line with that documented in the care plan.
- Recommendations of health professionals, including medical treatment recommended by a medical practitioner, in relation to the management of residents with swallowing difficulties have been implemented in line with our Eating, Drinking and Swallowing Policy.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

The Registered Provider is failing to comply with a regulatory requirement in

the following respect:

Transcribed medication prescriptions viewed by an inspector were not dual signed in line with nurses' professional guidelines.

5. 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:

All transcribed medication prescriptions are now dual signed in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais.

Proposed Timescale: Completed

Proposed Timescale: 07/09/2016

Theme:

Safe care and support

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

'End of life' care plans did not comprehensively outline the physical, psychological and spiritual needs of residents. Residents' individual wishes regarding place for receipt of 'end of life' care were not recorded.

Advanced directives were in place for some residents regarding resuscitation procedures. However improvement was required in recording of signatures by all members of the multi-disciplinary team involved in the decision-making process.

6. Action Required:

Under Regulation 13(1)(a) you are required to: Provide appropriate care and comfort to a resident approaching end of life, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned.

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

- We are revising our care plan documentation in respect of End of Life Care to ensure that the physical, psychological and spiritual needs of residents can be comprehensively outlined and their wishes regarding place for receipt of End of Life care are recorded.
- Where advanced directives are in place the signatures of all members of multi-disciplinary team involved in the decision making process will be clearly documented.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

Some residents had to wait for assistance with eating their meals.

7. Action Required:

Under Regulation 18(3) you are required to: Ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.

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

- An additional member of care staff has been rostered from 12pm to 9pm. Existing work practices have been reviewed to ensure adequate number of staff are available to assist residents at mealtimes. -

Completed

- The plans to convert the centre for the use of older persons only will reduce the number of residents in the dining room on the first floor by approximately 10. This will further enhance the dining experience for residents. - June 2017

Proposed Timescale: As above

Proposed Timescale: 30/06/2017

Theme:

Safe care and support

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

While there were procedures for return of out of date or unused medications, some medications in the medication storage trolley were out of date.

8. Action Required:

Under Regulation 29(6) you are required to: Store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products and dispose of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.

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

- This was brought to the immediate attention of all nurses and the pharmacy at the time of the inspection. The product identified was immediately removed.

- Arrangements are now in place to store any medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident in a secure manner, segregated from other medicinal products for safe disposal.

Proposed Timescale: 31/10/2016

Outcome 02: Safeguarding and Safety

Theme:

Safe care and support

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

Residents with behavioural and psychological symptoms of dementia were not appropriately supported and managed and as such posed a significant risk to themselves or other residents.

9. Action Required:

Under Regulation 07(2) you are required to: Manage and respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons, in so far as possible, in a manner that is not restrictive.

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

- Positive Behaviour Support Plans to assist staff to respond to behaviour that is challenging or poses a risk to the resident concerned or to other persons have been developed and implemented on 03/08/16.
- Monitoring in place in line with policy on Positive Behaviour Support to further enhance the Positive Behaviour Support Plans now in place.
- Training programme for all staff in Positive Behaviour Support commenced 04/08/2016.
- Training programme for all staff on dementia care commenced on 04/08/2016.
- On-going & Refresher training on Elder Abuse in place.
- Additional member of care staff is now rostered from 12pm – 9 pm

Proposed Timescale: Completed

Proposed Timescale: 07/09/2016

Theme:

Safe care and support

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

All staff had not received up to date training in managing challenging behaviours/BPSD.

10. Action Required:

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

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

- Training programme for all staff in Positive Behaviour Support commenced 04/08/2016.

- Training programme for all staff on dementia care commenced on 04/08/2016.
- On-going & Refresher training on Elder Abuse in place.

Proposed Timescale: 31/10/2016

Theme:

Safe care and support

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

Use of restraint in the centre was not in line with national restraint policy guidelines.

11. 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:

- To enhance resident's freedom of movement it has been decided to disable coded locks on 2 internal doors on a pilot basis for an initial period of 6 weeks. Subject to the pilot period being successful this will be implemented on a permanent This will facilitate freedom of movement between ground floor and first floor and access to the courtyard for all residents which is a secure and safe outdoor area.
- A full review of the use of bed rails has commenced. The review involves a critical review of each incidence of use of bed rails to determine compliance with policy. This will facilitate implementation of a more robust review system of bed rail use which will be supported by regular audits. The supporting policy and MDT clinical decision prescription process are currently being revised to ensure compliance with national policy and that the following are adequately provided for - commitment to least restrictive practice for shortest length of time, authorisation process, special precautions, risk of entrapment, consent, monitoring, review, audit, emergency use and duty of care.
- The risk management policy set out in Schedule 5 will be reviewed to ensure that the measures and actions in place are appropriate to control accidental injury.
- Arrangements are now in place to ensure the administration of chemical restraint where used is in line with national restraint guidelines and in particular that this is recorded on a clinical decision form

Proposed Timescale: 31/12/2016

Theme:

Safe care and support

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

There were peer to peer incidents recorded that were not appropriately investigated to outrule abuse.

12. Action Required:

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

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

Following completion of an internal review of peer to peer incidents abuse was not suspected, however, we will now investigate these and any future peer to peer incidents under the safeguarding guidelines.

Proposed Timescale: 30/09/2016

Outcome 03: Residents' Rights, Dignity and Consultation**Theme:**

Person-centred care and support

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

There was an absence of comprehensive assessment to ensure each resident with dementia had access to activities that met their individual interests and capabilities.

13. 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:

Currently a comprehensive assessment of all residents is being carried out to ensure residents have access to activities that meet their individual interests and capabilities. These assessments are being conducted by the newly appointed activities co-ordinators who will develop individualised activity programmes.

Proposed Timescale: 30/09/2016

Outcome 05: Suitable Staffing**Theme:**

Workforce

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

The number and skill mix of staff is not appropriate to meet the needs of the residents, in accordance with Regulation 5 and the size and layout of the designated centre.

14. 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:

- An additional member of care staff is now rostered from 12pm – 9pm.
- The recruitment process has commenced for the appointment of an additional Clinical Nurse Manager. The purpose of this post is to relieve the existing nursing staff of some of their administrative work load and thereby allow them to concentrate on the delivery and supervision of direct care to residents.
- A second post in activities is now in place.

Proposed Timescale: 15/10/2016

Theme:

Workforce

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

Not all staff have access to appropriate training to meet the needs of residents.

15. Action Required:

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

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

- Training programme for all staff in Positive Behaviour Support commenced 04/08/2016.
- Training programme for all staff on dementia care commenced on 04/08/2016.
- On-going & Refresher training on Elder Abuse in place.
- A comprehensive training programme is being developed to ensure that all staff receive all mandatory training on a planned basis in a timely manner. This will also include refresher training.

Proposed Timescale: 31/12/2016

Theme:

Workforce

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

Improvements were required in staff supervision to ensure safe moving and handling procedures were used for residents at all times.

A robust system for the supervision of new staff was required in the centre.

16. Action Required:

Under Regulation 16(1)(b) you are required to: Ensure that staff are appropriately supervised.

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

- Refresher Manual Handling Training will be provided for all staff.
- A programme of audits will be conducted to ensure compliance with best practice.
- All staff have been informed in writing of the requirement to at all times use appropriate techniques and equipment when moving and handling residents.
- The training programme mentioned under action 15 will include the necessary arrangements for induction and in-debt supervision of new staff on appointment
- The appointment of an additional Clinical Nurse Manager will enhance opportunities for increased supervision of new staff.

Proposed Timescale: 30/09/2016

Outcome 06: Safe and Suitable Premises

Theme:

Effective care and support

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

Provide external grounds that are suitable, and safe for use by residents.

17. 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:

To enhance resident's freedom of movement it has been decided to disable coded locks on 2 internal doors on a pilot basis for an initial period of 6 weeks. Subject to the pilot period proving successful this will be implemented on a permanent basis. This will facilitate freedom of movement between ground floor and first floor and access to the courtyard for all residents which is a secure and safe outdoor area.

Proposed Timescale: 31/10/2016

Theme:

Effective care and support

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

The ground floor did not provide a therapeutic environment that promoted a good quality of life for residents including residents with dementia.

18. Action Required:

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

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

- To enhance resident's freedom of movement it has been decided to disable coded locks on 2 internal doors on a pilot basis for an initial period of 6 weeks. Subject to the pilot period proving successful this will be implemented on a permanent basis. This will facilitate freedom of movement between ground floor and first floor and access to the courtyard for all residents which is a secure and safe outdoor area.

- 31st October 2016.

- The plans to convert the centre for the use of older persons only will create opportunities to improve the therapeutic environment and quality of life for all residents. – June 2017

Proposed Timescale: As above

Proposed Timescale: 30/06/2017

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:

Some resident moving and handling procedures did not reflect safe recommended procedures.

19. Action Required:

Under Regulation 04(1) you are required to: Prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.

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

- Refresher Manual Handling Training will be provided for all staff.
- A programme of audits will be conducted to ensure compliance with best practice.
- All staff have been informed in writing of the requirement to at all times use appropriate techniques and equipment when moving and handling residents.
- The training programme mentioned under action 15 will include the necessary arrangements for induction and in-debt supervision of new staff on appointment.

Proposed Timescale: 31/12/2016

Outcome 12: Notification of Incidents

Theme:

Effective care and support

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

Notification to HIQA was not submitted to inform of the following incidents as required.

- An incident of attempted self-harm that resulted in a hospital admission.
- Peer to Peer incidents that referenced potential abuse.

20. Action Required:

Under Regulation 31(1) you are required to: Give notice to the chief inspector in writing of the occurrence of any incident set out in paragraphs 7(1)(a) to (j) of Schedule 4 within 3 working days of its occurrence.

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

- In relation to non-reporting of the incident involving self-harm the resident concerned is in receipt of appropriate services and an agreed plan of care is in place. While the resident attempted self-harm no injury was sustained and therefore it was not reported. However as per care plan the resident did receive appropriate care. Any injuries resulting from attempted self-harm are recorded and will be reported to HIQA. If necessary incidents of attempted self-harm where no injury is sustained can in future be reported.
- Following completion of an internal review of peer to peer incidents abuse was not suspected, however, we will now investigate these and any future peer to peer incidents under the safeguarding guidelines.

Proposed Timescale: 30/09/2016

Theme:

Effective care and support

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

Three incidents of chemical restraint use in January and February 2016 were not notified to HIQA .at the end of each quarter 1 2016 as required.

21. Action Required:

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

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

Arrangements are now in place to ensure that all incidents of chemical restraint are accurately recorded, monitored and notified to HIQA as required.

Proposed Timescale: Completed

Proposed Timescale: 07/09/2016